Mechanisms of Change in Cognitive Behavioral Therapy for Depressed Biethnic Preadolescent Females: The Effect of Group Cohesion on the Treatment of Depressive Symptoms

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Childhood depression is a widespread disorder, with Latina girls experiencing higher rates of depression. Cognitive-Behavioral therapy is an empirically supported intervention for the treatment of depression. Group processes occurring during therapy, such as group cohesion, have been proposed as mechanisms through which positive change occurs, though their effectiveness have only begun to be explored. The proposed study will examine the effects of group cohesion in the context of a group CBT treatment on changes in depressive symptoms in biethnic youth. Specifically, this study will analyze self-reports of group cohesion and pre- and post-treatment depression scores of 8- to 14-year old Latina and European-American girls undergoing a CBT treatment for depression. It is hoped that this study will lead to an increased discernment in cultural sensitivity with regards to the delivery of interventions for the treatment of depression.

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Chapter One: Introduction

Childhood depression is a fairly widespread, stable, and recurring disorder (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984) affecting approximately 28% of children and adolescents (Lewinsohn & Clarke, 1999). Depression significantly impacts numerous areas of young persons' functioning, including their academic achievement, social performance, and family relations (Puig-Antich et al., 1993; Puig-Antich et al., 1985; Stark, 1990). Earlier-onset depression, moreover, is usually longer lasting (Birmaher et al., 1996; Lewinsohn, 1994b) and has been linked to substantial negative outcomes in adulthood, including increased likelihood of repeated depressive episodes, challenges with interpersonal relationships, marital discord, smoking, deviant behavior, and displeasure with life (Gotlib, Lewinsohn, & Seeley, 1998; Hammen & Rudolph, 2003; Kandel & Davies, 1986; Lewinsohn, Clarke, Seeley, & Rohde, 1994a; Rao, Ryan, Birmaher, Williamson, & Kaufman, 1995; Weisz, McCarthy, & Valeri, 2006).

Prior to adolescence, rates of depression are approximately equivalent in both boys and girls (Angold & Rutter, 1992; Costello et al., 2002). Once this developmental stage is reached, however, the incidence of depression increases significantly for females (Angold & Rutter, 1992; Costello et al., 2002), with girls being twice as likely as boys to suffer from depression when they reach 16 years of age (Culbertson, 1997; Fleming & Offord, 1990; Klerman & Weissman, 1989; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Lewinsohn et al., 1994a).

Cognitive behavioral therapy (CBT) is an empirically supported intervention for the treatment for early-onset depression (Asarnow, Jaycox, & Tompson, 2001; Birmaher et al., 1996; Kaslow & Thompson, 1998; Kazdin & Weisz, 1998; Lewinsohn & Clark, 1999; Weersing & Weisz, 2002). CBT has consistently been shown to be more effective than no-treatment for reducing symptoms in depressive youth, in both the short-term and long-term outlook; in regards to its effectiveness of treating depression in youth, it is generally on par with or just marginally superior to other psychological treatments (Curry, 2001; Weisz et al., 2006).

While a case has been made for the efficacy of group CBT for the treatment of childhood and adolescent depression, it is less clear which particular group processes are responsible for positive clinical outcomes (Oei & Browne, 2006). Group cohesion, or "the therapeutic relationship in group psychotherapy emerging from the aggregate of member-leader, member-member, and member-group relationships" (Burlingame, Furhriman, Johnson, 2001, p. 373), is posited to be a required ingredient for therapeutic success (Yalom, 1995). The extent of cohesion between group members has been shown to both increase over time spent in therapy (Lorenzten, Sexton, & Høglend, 2004; Schiff, Suvak, Antony, Bieling, & McCabe, 2007) and positively correlate with a reduction in a variety of clinical symptoms, including social anxiety, agoraphobia, depression, general anxiety, and functional impairment (Bieling, Perras, & Siotis, 2003; Budman et al., 1989; Hand, Lamontagne, & Marks, 1974; Schiff et al., 2007).

Latinos, a large number (64%) of whom are Mexican-Americans, are the largest ethnic minority group in the United States, comprising an estimated 14.8% of the

population (United States Census Bureau, 2006). Within the majority of existing studies, Latino children and adolescents have been found to display higher rates of depression than other youth (Kessler et al, 1994; Joiner, Perez, Wagner, Berenson, & Marquina, 2001; Roberts, Roberts, & Chen, 1997; Weinberg & Emslie, 1987) and are, correspondingly, at increased risk for suicide (Choi, Meininger, & Roberts, 2006; Hovey & King, 1996; Tortolero & Roberts, 2001; Vega, Gil, Zimmerman, & Warheit, 1993). While the preponderance of trials of depression treatments employ European-American participants (Scott & Watkins, 2004), a small number have demonstrated the effectiveness of CBT interventions in culturally diverse and low-income populations (Rossello & Bernal, 1999; Rossello, Bernal, & Rivera-Medina, 2008). The effect of demographic factors, including ethnic and racial differences, on nonspecific therapeutic factors, however, has not been adequately considered (Johnson, Burlingame, Olsen, Davies & Gleave, 2005) and, though group therapy has been shown to be effective in ethnic minorities (Bavington, & Majid, 1986), the impact of group cohesion on treatment effects in ethnic minority youth has yet to be investigated.

Researchers have only just begun exploring ethnic minority, particularly Latino, mental health, specifically experiences of depression and effectiveness of treatment with CBT. Moreover, the effect of group cohesion on the success of treatment for this particular population of youth has, to date, been disregarded. The proposed study will examine the effects of group cohesion in the context of a group CBT treatment on changes in depressive symptoms in biethnic youth. Specifically, this study will analyze self-reports of group cohesion and pre- and post-treatment depression scores of 8- to 14-

year old Latina and European-American girls undergoing a CBT treatment for depression. It is hypothesized that higher ratings of group cohesion will be associated with greater reductions of depressive symptoms, with the effect being more pronounced in Latinas than their European-American peers. It is hoped that this study will lead to an increased discernment in cultural sensitivity with regards to the delivery of interventions for the treatment of depression.

Chapter Two: Integrative Analysis

The following integrative analysis seeks to establish a connection between the treatment of depression, nonspecific therapeutic factors, and ethnic minority youth. It is hypothesized that enhanced experiences of group cohesion will be correlated with greater reductions in depressive symptoms, with the difference being more pronounced in ethnic minority girls, specifically Latinas, than in their European-American peers. Support for this hypothesis will be provided by means of an overview of the relationships between depression and CBT, group cohesion and depression, and ethnic minority status and depression. The epidemiology and enduring consequences of depressive disorders will be discussed in order to establish a rationale for the study of early-onset depression. Next, the cognitive theory of depression, features of CBT, and support for this particular treatment approach are outlined. Nonspecific therapeutic factors, particularly group cohesion, are subsequently reviewed; research concerning this mechanism of change is also summarized. Finally, ethnic minority experiences of depression and Latino cultural phenomena, specifically interpersonal behaviors, are explored.

Depression in Youth

Currently, three types of child and adolescent depressive diagnoses are recognized by the American Psychiatric Association's (APA) (2000) *Diagnostic and Statistical Manual of Mental Disorders (4th ed.) Text Revision* (DSM IV-TR): Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified. Major Depressive Disorder (MDD) is characterized by a severely depressed mood or loss of interest or pleasure in most activities (anhedonia) for most of the day, every day, during a

two-week period; for children, an irritable rather than sad mood may be observed. At least four supplementary symptoms of depression are required to be present before the diagnosis can be made; these include significant disturbances in appetite resulting in weight gain or loss, sleep difficulties, activity disturbances, fatigue, feelings of worthlessness or guilt, poor concentration or indecisiveness, and thoughts of death or suicide. The depressive episode must occur in the absence of any history of Manic, Mixed, or Hypomanic Episodes, and may not be due to psychosis, physical illness, drugs, or bereavement. Dysthymic Disorder is diagnosed when the depressed mood persists over a period of at least two years, with persistence defined as more days than not, and is accompanied by two of the previously described depressive symptoms. For children and adolescents, the requisite duration is shortened to one year and, again, an irritable rather than depressed mood may be noted. A diagnosis of Depressive Disorder Not Otherwise Specified (DDNOS) is accorded when the individual's debilitating symptoms do not meet criteria for MDD or Dysthymic Disorder (APA, 2000).

According to the World Health Organization, depression in individuals aged 15 to 44 is the leading cause of disability worldwide (Costello et al., 2002). In a similar age group, as approximated by the National Commorbidity Survey, 30-day prevalence rates approach 5%, with the highest incidence, 6.9% among the youngest age group (15- to 24-year olds) (Costello et al., 2002). Other estimates have placed childhood rates of depression at approximately 2.5%, increasingly dramatically to 8.3% for adolescents suffering from a depressive disorder at any given time (Birmaher et al., 1996). Cumulative incidence rates of depression by age 18 average around 28% (Lewinsohn &

Clarke, 1999). Adolescent depression, moreover, is believed to be under-identified by both parents and educators due to its less onerous internalizing nature (Agnold et al., 1987). Overall, it appears that childhood depression is a fairly widespread, stable, and recurring disorder (Kovaks et al., 1984), and that rates of depression are considerably higher during adolescence (Hankin & Abramson, 2001).

Depression is thought to be comorbid, or co-occurring, with numerous psychiatric disorders, particularly anxiety, conduct, somatic, and eating disorders (Agnold & Rutter, 1992; Rhode, Lewinsohn, & Seeley, 1991). A presence of a comorbid disorder has been linked to a more prolonged course, an increased probability of relapse, a greater propensity for suicide, and a poorer response to psychopharmaceuticals (Rohde et al., 1991). The average duration of a depressive episode in children is between 8 and 17 months (Birmaher et al., 1996; Kovacs et al., 1984; Goodyer, Herbert, Tamplin, Secher, & Pearson, 1997) and approximately 70% of children suffering from Dysthymic Disorder continue on to develop MDD (Birmaher et al., 1996).

While the number of children experiencing depression has increased, the age of onset has decreased (Klerman & Weissman; 1989). This is of great concern as depression has a significant impact on the lives of children and adolescents who experience it at a young age (Klerman & Weissman, 1989). Childhood and adolescent depression affects various areas of the young person's life, including academic achievement, family functioning, and social functioning (Puig-Antich et al., 1993; Puig-Antich et al., 1985; Stark, 1990). Moreover, experiencing early-onset depression places children and adolescents at increased risk for experiencing recurring depressive episodes (Birmaher et

al., 1996; Hammen & Rudolph, 2003; Kovacs et al., 1984; Lewinsohn, Rohde, Klein, & Seeley, 1999), and youth with previous histories of depression are more likely to have future depressive episodes that are more protracted (Birmaher et al., 1996; Lewinsohn et al., 1994b). Furthermore, early-onset depression is associated with numerous other deficits in adaptive functioning throughout the lifespan, specifically a greater likelihood of substance abuse, increased probability of smoking, deficiencies in interpersonal relationships, marital distress, and a greater chance of experiencing general dissatisfaction with life (Hammen & Rudolph, 2003; Kandel & Davies, 1986; Lewinsohn et al., 1994a; Rao et al., 1995; Weisz et al., 2006). Young adults (aged 18 to 24) who suffered from adolescent depression are also less likely to complete college, and are liable to earn smaller salaries, become an unmarried parent, involve themselves in criminal activity, and, in general, experience stressful life events (Lewinsohn et al., 1999). They are, additionally, increasingly likely to attempt and successfully commit suicide (Gould et al., 1998; Schaffer et al., 1996).

During childhood, prevalence of depression is equivalent in boys and girls (Angold & Rutter, 1992; Costello et al., 2002). This trend continues until adolescence, at which time the incidence of depression increases for females (Angold & Rutter, 1992; Costello et al., 2002), who then, compared to males, suffer at a rate of 2:1 (Culbertson, 1997; Fleming & Offord, 1990; Fergusson, Horwood, & Lynskey, 1993; Klerman & Weissman, 1989; Lewinsohn et al., 1993). The age at which the difference between male and female rates of depression becomes apparent ranges from 13 to 15 (Hammen & Rudolph, 2003) and this disparity continues to exist, and even rise, in adulthood (Hankin

& Abramson, 2001). Females' experience of depression is, furthermore, more severe than males' (Kandel & Davies, 1982; Stark, Sander, Yancy, Bronik, Hoke, 2000). As such, adolescence may signify an essential time for increased susceptibility to depression for girls (Hankin & Abramson, 2001); gender is, thus, an important consideration in the conceptualizing, assessing, and treatment of depression (Culbertson, 1997).

Theories of Depression

Several theories concerning the etiology of childhood and adolescent depression have been proposed. Interpersonal, biological, behavioral, and cognitive models are the major explicating mechanisms, and, within the cognitive perspective, Beck's (1967) cognitive theory, the Hopelessness theory (Abramson, Metalsky, & Alloy, 1989), and Response Styles Theory (Nolen-Hoeksema, 1991) are the most prevailing (Abela & Hankin, 2008). The various theories of depression will be discussed, though cognitive theories, as the main contributing influences on the development of CBT, will be the primary focus.

The interpersonal theory of depression asserts that the excessive search for reassurance, especially with regards to one's self-worth, is an essential feature of depression (Coyne, 1976). The theory proposes that mildly depressed individuals frequently seek reassurance from others; victims to their suspicious dispositions, they question the speakers' statements and request further assurance to allay their doubts (Joiner & Metalsky, 1995). As a consequence of this excessive reassurance-seeking, depressed persons are rejected by these targets, who easily become disenchanted with them, leaving the depressed individual even more depressed (Coyne, 1990). Thus,

individuals' poor social skills lead to social rejection and subsequent social withdrawal, stripping these persons of interpersonal relationships and their associated positive social reinforcement.

Additionally, depression is thought to have a genetic basis. Hereditary studies have reported that close relatives of those who suffer from various affective disorders are, in comparison to those without afflicted relatives, approximately ten times more likely to suffer from similar disorders (Gershon, Bunney, Leckman, Van Eergewegh, & DeBauche, 1976; Hamet & Tremblay, 2005). Depression is also though to be caused by deficient activity of monoaminergic neurons, as outlined in the monoamine hypothesis; specifically the neurotransmitters norepinephrine and serotonin have been implicated as causal factors. Abnormalities in the areas of the prefrontal cortex, basal ganglia, hippocampus, thalamus, cerebellum, and temporal lobe have also been observed in the brains of depressed persons (Soares & Mann, 1997).

The behavioral model of depression (Lewinsohn, 1974) maintains that environmental stressors lessen the amount of positive reinforcement a person receives; individuals are hypothesized to become depressed when they are unable to suitably cope with this reduction in positive reinforcement. The situation is exacerbated when these individuals, markedly self-aware of their coping skills deficit, become increasingly self-critical and withdraw from social contact, further reinforcing their original predicament (Lewinsohn, 1974).

Beck's (1967) Cognitive Theory of Depression purports that the development and maintenance of depression occurs as a consequence of depressed individuals' biases

toward the negative interpretation of events. The theory posits three explicating concepts: schemas, the cognitive triad, and cognitive errors (or faulty information processing) (Beck, 1967). Schemas are viewed as established patterns of cognition that shape a person's understanding of events (Beck, Shaw, Rush, & Emery, 1979). When encountering a certain situation, a related schema is activated and shapes the way an individual conceptualizes it. In such a scenario, particular individuals' schema will, at times, attend to the negative aspects and ignore the positive features of the situation. These individuals, typical of depressed persons, are hypothesized to be in possession of negative schemas that, when activated, are successful in distorting their understanding of the self, world, and future (Beck, 1967; Beck, 1976). In other words, individuals' construal of their environment and subsequent affective and behavioral reactions are the result of the activation of cognitive schemas; when in possession of maladaptive schemas, interpretations of such events are themselves negative, often resulting in a depressive state.

Next, Beck (1967) describes the cognitive triad, or those specific cognitive patterns (or schemas), originating by way of early developmental experiences, that form a person's negative view of the self, world, and future. The first can be observed in depressed individuals' proclivity for self-ascribing blame for negative events because of such perceived internal deficiencies as personal inadequacies or general feelings of worthlessness; they believe themselves to be indisposed and disadvantaged (Beck et al., 1979). The depressed person's view of the world, tainted by a propensity for perceiving incidents in a negative light, is also flawed. These individuals believe that the world is

making excessive demands of them and introducing insurmountable obstacles that will ultimately hinder the achievement of their goals. They are likely to attribute negative motives and causes for various events when less harmless ones would be more apt, and view the world as burdensome, precarious, and menacing (Beck, 1967). The third damaging cognitive pattern involves the depressed person's negative view of the future; this individual can be expected to possess overly unfavorable and hopeless outlooks, believing any existing predicaments to be permanent and ultimately leading to inevitable failure (Beck, 1967). Generally, the negative cognitive triad is hypothesized to impede healthy and accurate information processing and facilitate a more pessimistic explanatory style, preventing effective coping and, consequently, leading to depression (Weersing & Weisz, 2002).

Finally, Beck's third element concerns the existence and implementation of cognitive errors, those that induce the overly negative interpretation, in the form of absolutistic thinking, overgeneralizations, and selective abstraction, among others, of events. Again, as a result, events are misconstrued and negative beliefs are maintained, even in the face of conflicting evidence, resulting in the creation of negatively distorted automatic thoughts (Beck, 1967). As such, depression results when individuals' maladaptive schemas concerning themselves, their worlds, and their futures are activated in the face of typically stressful life events and result in the formation of distorted cognitions, or negative automatic thoughts, which in turn beget depressed moods and behaviors (Beck, 1967; Kovacs & Beck, 1978).

Extensive evidence supporting Beck's cognitive theory of depression in children exists; specifically, the existence of depressive self-schemas, the negative cognitive triad, and cognitive errors has been substantiated. Negative self-schemas have been linked to depression, even in children as young as eight years of age (Hammen & Zupan, 1984; Jaenicke et al., 1987; Prieto, Cole, & Tageson, 1992; Zupan, Hammen, & Jaenicke, 1987). Moreover, Beck's conceptualization of the cognitive triad in children has also been corroborated. Depressed children have been found to exhibit a significantly greater number of negative cognitions concerning the self, world, and future, compared to anxious and nondepressed controls (Asarnow et al., 2001; Kaslow, Stark, Printz, Livingston, and Tsai; 1992; Stark, Humphrey, Laurent, Livingston, Christopher, 1993). Finally, depressed children display significantly more negative automatic thoughts (Kazdin, 1990) and experience cognitions that are considerably more biased (Haley, Fine, Marriage, Moretti, and Freeman; 1985; Kendall, Stark, & Adams, 1990), than their nondepressed counterparts, providing evidence for a distortion in these individuals' processing of information.

Beck's theory (1967), along with the Hopelessness theory of depression (Abramson et al., 1989), is a stress-diathesis model, in which dysfunctional cognitive processes are thought to become activated subsequent to the occurrence of a negative life event. Thus, in the above-described cognitive theory, depressive schemas are galvanized by life stressors, triggering maladaptive cognitive processes concerning the self, world, and future.

Similarly, Hopelessness theory (Abramson et al., 1989), a reformulation of the

Helplessness theory (Abramson, Seligman, & Teasdale, 1978; Seligman, 1975), asserts that persons possessing a more depressive inferential style are, when exposed to life stressors, apt to develop symptoms of depression. Three negative inferential styles are posited to lead to the development of depression. Causal inferences, or assumptions regarding the cause of an event, are deemed global and stable. Moreover, depressed individuals are said to catastrophize the outcome of negative events, as described the second inferential style of inferred consequences. Finally, inferences about the self include viewing oneself as flawed and deficient, incapable of producing a change to a negative situation. Possession of any of these styles increases the likelihood that a person will develop hopelessness, and in turn depression, when confronted with a negative life event. Support has been garnered for the vulnerability-stress model (Hankin, Abramson, Miller, & Haeffel, 2004; Metalsky & Joiner, 1997), and substantial evidence for the existence of the negative inferential styles in children and adolescents has been collected (Lakdawalla, Hankin, & Mermelstein, 2007).

The Response Style Theory posits that depressed individuals' responses to their symptoms dictate their ensuing experience of their affliction (Nolen-Hoeksema, 1991). Of the response styles, of which there exist three, rumination, or directing one's focus to one's negative thoughts and feelings, thereby escalating one's experience of them, is thought to maintain depressive symptoms. This is hypothesized to occur because of the increased attention on and recall of negative events, reducing one's experiences of control over outcomes. Rumination is also believed to moderate helpful behaviors, lessening exposure to situations that might potentially increase a personal sense of

control. Finally, its negative influence is also displayed in its intrusive effect on efficient problem-solving, as is accomplished by increasing access to negative thoughts and hindering engagement in positive behaviors. The additional response styles of problem solving and distraction are presumed to reduce depressive symptoms by encouraging the active altering of adverse circumstances and the engagement in beneficial activities (Nolen-Hoeksema, 1991). The Response Styles Theory has been utilized to conceptualize depression in women and adolescent girls, postulating that the increased rate of depression in females is due to their proclivity towards the ruminative response style, with their male counterparts tending towards the distraction response style (Nolen-Hoeksema, 1995). Finally, ruminative response styles has been linked with increased depressive symptoms in adults (Butler & Nolen-Hoeksema, 1994; Nolen-Hoeksema & Morrow, 1991) and in children (Schwartz & Koenig, 1996).

Cognitive Behavioral Therapy for Depression

Cognitive Behavioral Therapy (CBT) is founded on the theoretical postulate that individuals' conceptualizations of their experiences subsequently influence their affect and behavior (Beck et al., 1979). When their cognitions, such as beliefs relating to the cognitive triad, based on earlier developed schemas, are distorted, their activation can trigger maladaptive information processing, thus leading to the development of depressive symptoms. While CBT treatment packages are varied and emphasize an array of interventions (Lewinsohn & Clarke, 1999), the central tenet underlying the multitude of CBT programs is that therapeutic change is generated when patients are successful at transforming their dysfunctional cognitions and behaviors (Curry & Reinecke, 2003).

This is attempted through the guidance of the therapist, who assists patients in examining their cognitions and collaboratively identifying and altering those negatively distorted and dysfunctional thoughts that are responsible for the patients' depressive state (Beck et al., 1979).

The successful application of CBT dictates the employment of various cognitive and behavioral techniques. Cognitive strategies seek to assist patients in defining and assessing their faulty cognitions in order to reduce depressive symptoms and do so by instructing the patients to: (1) Identify and attend to their negative automatic thoughts; (2) Become cognizant of the association between their thoughts, affects, and behavior; (3) Weigh the evidence for and against their negative thoughts; (4) Detect and restructure distorted cognitions, replacing them with more accurate interpretations; and (5) Develop the ability to modify maladaptive beliefs (Beck et al., 1979).

Behavioral techniques are employed with the intention of altering behavior, extracting thoughts associated with behaviors, and testing the accuracy of particular dysfunctional cognitions. Specific methods include teaching patients how to engage in pleasurable and enjoyable activities, as well as how to improve relational problem solving skills; relaxation, self-control, and coping skills are also imparted in order to assist with the management of the patients' emotions (Curry & Reinecke, 2003; Lewinsohn & Clarke, 1999). Behavioral interventions, the focuses of which are general symptom relief, are frequently emphasized during the initial stage of therapy (J.S. Beck, 1995), though cognitive mediations are occasionally instituted earlier on when the patient is only moderately depressed (Rush & Beck, 1977).

Efficacy of CBT for Depressed Children and Adolescents

Research on the treatment of depression in children and adolescents has emerged only relatively recently (Asarnow et al., 2001; Weersing & Weisz, 2002), and is lagging behind that of the treatment of adult depression and other child disorders (Kaslow & Thompson, 1998). The paucity of research has been hypothesized to exist as a result of historical uncertainties regarding whether depression could actually exist during youth, and as a consequence of inconsistencies with assessment and diagnostic practices. The less disruptive nature of depression, as compared to externalizing and even other internalizing disorders, has also been put forth as a possible justification for this dearth (Kaslow & Thompson, 1998). In the extant literature, cognitive-behavioral therapy (CBT) is the most often evaluated (Curry, 2001; Weersing & Weisz, 2002) and the most empirically endorsed psychotherapeutic intervention for the treatment of child and adolescent depression (Birmaher et al., 1996; Curry, 2001; Kaslow & Thompson, 1998; Lewinsohn & Clark, 1999; Reinecke, Ryan, & Dubois, 1998). It is, thus far, the only psychotherapeutic treatment to be accorded with the label "probably efficacious" (David-Ferdon & Kaslow, 2008). Large effect sizes concerning the impact of CBT for treatment of youth depression have been found (1.27, Lewinsohn & Clarke, 1999; 1.02, Reinecke et al., 1998). Those studies supporting the efficacy of CBT in a group context for the treatment of depression in both children and adolescents will be reviewed presently.

Stark and colleagues (1987, 1991) conducted two studies involving depressed children. In the first trial, 29 depressed fourth- to sixth-grade students were assigned to the following 12-session group interventions: (1) self-control therapy, a cognitively

focused CBT condition; (2) behavior problem-solving therapy, a mainly behavior focused CBT treatment; or (3) a wait-list control (Stark, Reynolds, & Kaslow, 1987). Post-intervention analysis revealed that children in both active treatment groups reported fewer depressive symptoms than the participants in the wait-list group; neither CBT condition was proven superior to the other. At eight-week follow-up, gains for both active groups were maintained, with a greater percentage of children from the self-control condition remaining so. This study provides corroboration for the effectiveness of CBT treatments for the treatment of depression as compared to no-treatment controls, and evidence of its long-term effectiveness over other therapeutic interventions.

In a second study, Stark et al. (1991) affirmed that CBT, relative to treatment at usual in the form of school counseling, is more effective at reducing depressive symptoms following acute treatment. Comparing an enhanced version of self-control therapy (CBT) to traditional school counseling, 26 fourth- to seventh-grade students with elevated depressive symptoms were assigned to 24 to 26 sessions over a period of 14 weeks. Both groups improved with respect to depressive symptoms, with the CBT group exhibiting increased progress; differential treatment gains were no longer found at seven-month follow-up, results that may have been complicated by differential attrition (Stark, Rouse, & Livingston, 1991).

Similar results, demonstrating the superiority of CBT over no-treatment in the reduction of depressive symptoms in children, have been found in other studies (Butler, Miezitis, Friedman, & Cole, 1980; Kahn, Kehle, Jenson, & Clarke, 1990; Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997). In summary, CBT has been found to

be superior to no-treatment and wait-list controls and comparable to other active treatments; CBT has also demonstrated success at reducing depressive symptoms following immediate completion of treatment and at long-term follow-up. Altogether, these childhood treatment studies provide support for the efficacy of CBT in the treatment of childhood depression.

Empirical studies of adolescents have also confirmed the effectiveness of CBT as a therapeutic intervention for the treatment of depression (David-Ferdon & Kaslow, 2008). Lewinsohn and colleagues (1990) randomly assigned 59 outpatients, aged 14 to 18, diagnosed with various depressive disorders, to the Adolescent Coping with Depression Course (CWD-A), CWD-A with parent group (CWD-A+P), or a wait-list condition. At the completion of treatment, both groups displayed a significant reduction in depressive symptoms, as measured by self-reported measures of depression, with the CWD-A+P group also evidencing improvement in girls' experience of depression based on the parent-rated depression measures. Treatment gains were maintained at two-year follow-up (Lewinsohn et al., 1990). Slightly modified replication studies duplicated earlier findings that CBT is superior to no-treatment in treating depression and elaborated on previous findings by demonstrating that extended implementation of CBT can lead to continued improvements in previously non-responsive participants (Clarke, Rhode, Lewinsohn, Hops, & Seeley, 1999; Lewinsohn, Clarke, Rohde, Hops, & Seeley, 1996).

The Treatment of Adolescents with Depression Study (TADS), by the National Institute of Mental Health, evaluated the effectiveness of four interventions for the treatment of depression (March et al., 2004). Three hundred and twenty-seven moderately

to severely depressed adolescents, aged 12 to 17 (European-American: 74.0%; African American: 11.3%; Latino: 9.8%), were treated with either CBT, fluoxetine, CBT plus fluoxetine, or placebo. The results indicated that fluoxetine alone was effective at reducing depressive symptoms, but to a lesser degree than fluoxetine plus CBT; CBT was not significantly more effective than placebo. It is worth mentioning that an atypical CBT protocol was utilized during treatment, as cognitive interventions were restricted to the six weeks of therapy, and that adolescents in the fluoxetine only condition experienced significantly more suicidal ideation than those participants assigned to other treatments. As this was not the case with individuals in the CBT plus fluoxetine condition, it was theorized that CBT may have played a protective role by shielding depressed adolescents from experiencing this sequela (Emslie et al., 2006; March, Silva, & Vitiello, 2006). Moreover, the use of varied therapists from diverse sites and the severity of the depression experienced by the treated group may have moderated the potential effects of the CBT condition (Weersing & Weisz, 2002).

The observed trend across these adolescent treatment studies is that CBT reduces symptoms of depression to a greater extent than no-treatment or wait-list controls, both immediately following treatment and at long-term follow-up. CBT is analogous to alternative psychotherapies with regards to its success at reducing depression; when compared to psychopharmacological treatments, CBT is not superior but instead akin to placebo, unless combined with fluoxetine, which increases its efficacy to surpass pharmacological treatment alone.

Though CBT has shown to be effective in the treatment of child and adolescent depression, less is known about the precise mechanisms through which it exerts its effects. Various group processes have been hypothesized as likely mechanisms of change; the role they play in achieving positive clinical outcomes will be discussed presently.

Group Cohesion

Though the conscientious application of specialized aspects of the selected therapy is essential to its success (Beck et al., 1979), it has been hypothesized that therapeutic change is also contingent on nonspecific elements of treatments (Hubble, Duncan, & Miller, 1999). Within the context of individual therapy, the therapeutic alliance, or the "affectively charged collaborative relationship between the therapist and patient that emerges as the participants engage in work on the patient's problems (Joyce, Piper, & Ogrodniczuk, 2007, p. 272), has consistently been linked to positive therapeutic outcomes (Budman et al, 1989; Horvath, 1994; Joyce et al., 2007; Lorentzen et al., 2004; Martin, Garske, & Davis, 2000; Marziali, Monrose-Blum & McCleary, 1997).

According to Beck et al. (1979), essential to the development of a productive interaction are certain therapist traits, due to their supposed effects on facilitating the modification of negative cognitive distortions. These qualities, specifically warmth, accurate empathy and genuineness, allow the therapist to comprehend the way the patient structures and responds to life events, and encourages greater patient disclosure. The therapeutic relationship, thus, is founded on trust, rapport, and collaboration, qualities which promote a secure interaction between both participants, foster direct

communication, and, eventually, enable the progress of the patient towards the ultimate remission of depressive symptoms (Beck et al., 1979).

Though CBT had initially been conceptualized as an individual therapy, its application in a group context has, in the recent past, become increasingly prevalent, perhaps due to the associated benefits of time and cost effectiveness, with positive results (Oei & Browne, 2006). Group cohesion, a group therapy mechanism of change analogous to the therapeutic alliance in individual therapy, is posited to be a required ingredient for clinical success (Yalom, 1995). Though definitions of the construct are numerous and varied (Bednar & Kaul, 1994), group cohesion has generally been described as "the therapeutic relationship in group psychotherapy emerging from the aggregate of member-leader, member-member, and member-group relationships" (Burlingame et al., 2001, p. 373). Furthermore, it has been associated with such intrapersonal elements as acceptance, belonging, and personal commitment to the group, and intragroup components including compatibility among the group members, mutual liking, bonding, and support (Burlingame et al., 2001; Marziali et al., 1997).

Group cohesion is posited to cultivate productive therapeutic climates that produce positive clinical outcomes (MacKenzie, 1998). It is further hypothesized to increase feelings of support, security, and acceptance among group members, promoting active participation and greater self-disclosure (Corey & Corey, 2006). Improved experience of cohesiveness in groups is thought to be predictive of increased risk-taking, understanding, listening, and productive expressions concerning intragroup conflict (Yalom, 1995). Furthermore, numerous studies have explored the correlation between

group cohesion and various organizational aspects of groups related to positive therapeutic outcomes, including reduced levels of absenteeism and turnover (Keller, 1983).

Research has revealed mixed results concerning the relationship between group cohesion and clinical outcomes. Hand and colleagues (1974) treated 25 patients suffering from agoraphobia using 12 sessions of in-vivo exposure (flooding), a CBT technique. Patients were divided into structured groups that fostered cohesion and those that were relatively unstructured and minimally exposed members to the group's effect. Though levels of improvements following the acute treatment stage did not differ between groups, structured groups promoting cohesion, compared to unstructured groups, exhibited significantly fewer phobic symptoms at three- and six-month follow-up assessments.

Budman and colleagues (1989) examined the association between alliance, cohesion, and treatment outcome. Videotaped sessions of 90 depressed and anxious outpatients in 12 short-term therapy groups were observed and assessed using a modified Penn Helping Alliance Scale (HAq-II; Luborsky et al., 1996) and the Harvard Community Health Plan Group Cohesiveness Scale (HCHP-GCS II; Budman, 1987); the experience of the whole group rather than just those of the separate members was taken into account when considering the latter construct. Results indicated that both alliance and cohesion were related to the other, to reductions in symptoms, and to increases in self-esteem.

Tschuschke and Dies (1994) examined the relationships between five therapeutic factors, of which cohesiveness was one, in two long-term inpatient groups. Severely neurotic and personality-disordered patients were treated using psychoanalytic therapy and assessed with various outcomes measured at 12 and 18 months post-treatment. Patients exhibiting improvement were more likely to report experiencing a high level of cohesion during group therapy, leading the authors to propose that the cohesiveness of the group is a critical element of effective group therapy.

Taft and colleagues (2003), in their study of mechanisms of change in psychotherapy, investigated the influence of participation in a 16-week group CBT intervention on post-treatment levels of physical and psychological abuse in 107 violent men. Though ratings of therapist alliance, as measured by the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), were the strongest predictors of outcome, group cohesion, assessed using the Group Environment Scale (GES; Moos, 1986) was also related to outcomes measures of violence at 6-month follow-up assessment (Tafy, Murphy, King, Musser, & DeDeyn, 2003).

Schiff and colleagues (2007) treated 34 adults diagnosed with Social Phobia, 50% of whom were comorbid for a mood disorder, using time-limited group CBT. Individual members provided their experience of group cohesion via the Group Cohesion Scale-Revised (GCS-R; Treadwell, Laverture, Kumar, & Veeraraghavan, 2001) mid- and post-treatment, and social phobia, depression, and anxiety related symptoms were assessed following completion of treatment. Group cohesion ratings were found to increase throughout group therapy and were significantly related to improvements on outcome

measures, providing support for the consideration of nonspecific therapeutic factors in clinical treatment.

Several studies have provided differing evidence, failing to find a meaningful relationship between the group cohesion and treatment outcomes (Lorentzen et al., 2004; Marziali et al., 1997; Oei & Browne, 2006; Teasdale, Walsh, Lancashire and Mathews, 1977; Woody & Adessky, 2002). The absence of a coherent, comprehensive, and universally accepted definition of group cohesion, in addition to variations in its measurement methods, have been suggested as possible explanations for these inconsistent results (Budman et al., 1989; Hornsey, Dywer, & Oei, 2006; Woody & Adessky, 2002). Further research is needed to elucidate these incongruities, as an increased awareness of these mechanisms of change will enhance the therapeutic experience and contribute to potential positive effects of these interventions.

Latino Youth and Depression

The term Latino or Hispanic is used to describe individuals of "Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race" (Office of Management and Budget, 1997). While the terms are often used interchangeably, the term Latino will be used throughout the remainder of this document to describe individuals from the above listed subgroups, as the label Hispanic has been criticized for its narrow and exclusionary implications (Rochín & de la Torre, 1996).

Latinos, the majority (64%) of whom are Mexican-Americans, constitute the largest ethnic minority group in the United States, comprising an estimated 14.8% of the population (United States Census Bureau, 2006). Socioeconomic data indicates that

Latinos are less likely than European-Americans to graduate from high school (57% compared to 88.7%, respectively), more inclined to be unemployed (8.1% compared to 5.1%), and liable to earn less, with 21.4%, compared to 7.8% of European-Americans, living below the poverty line. Moreover, a parallel trend exists in Latino youth, with 28% living in poverty, as contrasted with 9.5% of their European-American counterparts (Ramirez & De la Cruz, 2002).

Given the paucity of research concerning adolescent depression in general, the scarcity of data regarding the ethnic minority experience of depression is to be expected. Within the majority of existing studies, Latino children and adolescents have been found to display higher rates of depression than other youth (Kessler et al, 1994). However, contradictory evidence, in support of an absence of ethnic differences in rates of mental disease, also exists (Doerfler, Felner, Rowlison, Raley, & Evans, 1988; Garrison, Addy, Jackson, McKeown, & Waller, 1990, Kandel & Davies, 1982); methodological differences have been proposed to explain this discrepancy (Roberts et al., 1997). Studies corroborating the first claim will be outlined presently.

In an examination of 5,496 ethnically diverse 10- to 17-year-olds, Mexican-American youth were the only group to exhibit increased rates of depression, after controlling for socioeconomic status, gender, and age; Mexican-American girls, moreover, reported the highest rates of depression, while European-American boys described experiencing the fewest depressive symptoms (Roberts et al., 1997). Joiner and colleagues (2001), Roberts (1994), Roberts & Shoban (1992), Siegel and colleagues (1998) and Weinberg & Emslie (1987), in their respective studies of several thousand

multiethnic youth, have found corresponding evidence for the increased prevalence of depression in ethnic minorities, particularly Latino adolescents.

Latino youth, correspondingly, are also at increased risk for suicide (Choi et al., 2006; Hovey & King, 1996; Roberts et al., 1997; Tortolero & Roberts, 2001; Vega et al., 1993). In an analysis of self-report data from over 2000 diverse middle school students, Mexican-American youth in general, and girls in particular (21.6%), reported engaging in suicidal ideation to a much higher degree than other ethnic minorities, as well as than the European-American majority, whose males were found to report the fewest suicidal thoughts (13.1%) (Roberts & Chen, 1995). Furthermore, results from the Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey indicates that, compared to their European-American and African-American peers, Latino high-school students are significantly more likely to consider attempting suicide, form a suicide plan, and attempt suicide (Kann & Kinchen, 1998).

Several explanations for this pervasiveness have been proposed. Low childhood socioeconomic status, as assessed by income, educational attainment, and occupation, is more prevalent among Latino youth (Proctor & Dalaker, 2002; Ramirez & De la Cruz, 2002), and has been linked to increased rates of depression and other mood disorders, as reflected in both higher immediate and lifetime risks of depression (Costello et al., 1996; Cuéllar & Roberts, 1997; Gilman, Kawachi, Fitzmaurice, & Buka, 2002; Golding & Lipton, 1990). Acculturation, or "the process that occurs when an individual or group from a given culture is required to adapt and adjust to the cultural worldviews, customs, and traditions of another group" (Marsella & Yamada, 2000, p. 14), and the

accompanying acculturative stress, have also been posited as explanatory factors for the elevated prevalence rates of depression and suicidal ideation in Latino youth (Hovey & King, 1996; Roberts & Chen, 1995; Vega et al., 1993). Research also points to the causal role of various cultural phenomena, including fatalism, or belief in an external locus of control, in the development of mental distress of Latino youth (Mirowsky & Ross, 1984; Neff & Hoppe, 1993; Ross, Mirowsky, and Cockerham, 1984).

Within the field of psychology, ethnic groups continue to be marginalized (Hays, 1995) and research on psychosocial interventions has failed to display adequate cultural sensitivity (Bhugra & Bhui, 1998; Kaslow & Thompson, 1998). In a methodological analysis of treatments of depression, anxiety, conduct problems, and ADHD, it was noted that a mere 40% of studies reported participant racial and ethnic demographics; 70% failed to include any socioeconomic status data (Weisz, Doss, & Hawley, 2005). In those that did describe participants' racial and ethnic makeup, European-Americans, distantly followed by African-Americans, were consistently the most sampled. In order to better serve the growing multicultural population, more inclusive sampling procedures must become the standard.

While the preponderance of trials of depression treatments employ European-American participants (Scott & Watkins, 2006), a small number have demonstrated the effectiveness of various therapeutic interventions in culturally diverse and low-income populations (Araya et al, 2003; Bolton et al., 2003; Jacobs, Bhugra, & Mann, 2002; Miranda et al, 2003; Organista, Munoz, & Gonzales, 1994). In particular, Rossello & Bernal (1999) randomly assigned 71 Puerto Rican adolescents meeting DSM-III criteria

for a diagnosis of depression to individual CBT, Interpersonal Therapy (IPT), or a wait-list condition. Both active treatments were superior to wait-list condition in reducing depressive symptoms at both post-treatment and three-month follow-up assessments. In a replication study assessing effectiveness of CBT and IPT in treating depression symptoms in Puerto Rican youth, Rossello, Bernal, & Rivera-Medina (2008) found that, while both interventions were successful in reducing patients' experiences of depression, CBT produced significantly greater declines. Although initial results seem promising, effectiveness studies sampling ethnic minority populations are in their early stages and additional research needs to be undertaken before cogent conclusions can be drawn.

While nonspecific therapeutic factors have shown to positively affect clinical outcomes (Bieling, et al., 2003; Budman et al, 1989; Schiff et al., 2007), the influence of demographic factors, including ethnic and racial differences, on these variables has not been adequately considered (Johnson, et al., 2005). In one study, however, this relationship was examined in 79 Puerto Ricans (Bernal, Bonilla, Padilla-Cotto, & Perez-Prado, 1998). Results from data collected via self-questionnaires following the completion of therapy revealed that therapeutic alliance correlated with the efficacy of treatment, accounting for 45% of the variance in effectiveness.

In another study that also examined various mechanisms of therapeutic change, Rohde and colleagues (2006), in an effort to analyze demographic, psychopathological, and psychosocial factors affecting recovery time in depressed adolescents, randomly assigned 114 13- to 17-year olds (European-American: 71%; African-American: 1%; Latino: 1%; Asian American: 1%, Native American: 1%; "Other" or "Mixed": 25%)

diagnosed with MDD to either a CBT intervention or a life-skills tutoring control. Consisting of 16 two-hour biweekly sessions, the CBT intervention combined cognitive and behavioral techniques, including mood monitoring, social skills, relaxation, and cognitive restructuring, whereas the life skills-tutoring condition instructed adolescents on various fundamental life skills in a tolerant and supportive milieu. In addition to other variables, time to recovery was predicted by participation in the CBT treatment, with faster time to recovery among European-American adolescents in CBT. As ethnic minority youth had comparable recovery times in both treatment conditions, the authors proposed that depressed, ethnic minority adolescents may benefit from an increased focus on the therapeutic relationship to a greater extent than their majority, European-American counterparts (Rohde, Seeley, Kaufman, Clarke, & Stice, 2006).

Though group therapy has shown to be effective in ethnic minorities (Bavington, & Majid, 1986), the effect of group cohesion on treatment effects in ethnic minority youth, specifically in the context of cognitive-behavioral therapy for the treatment of depression in Latino adolescents, has yet to be investigated.

Latino Cultural Phenomena

Latino culture has been described as collectivist (Hofstede, 1980; Ramirez, 1990; Triandis, Marín, Lisansky, & Betancourt, 1984), a theory that promotes the integration and interdependence of group members (Valera et al., 2004). Harmonious relationships, wherein intense emotional associations often occur, are emphasized (Markus & Kitayama, 1991; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Collectivism can be contrasted with individualism, in which independence, competition, and minimal

concern for the views of others are valued (Hostede, 1980; Triandis et al., 1988; Triandis, McCusker, & Hui, 1990); ambivalent relationality, or a relationship in which one weighs the cost and benefits of the interaction, leading to relationships that are superficial and transitory in nature, is often the norm (Oyserman, Coon, Kemmelmeier, 2002). Mexican-origin and European-American university students, assessed with the Individualism-Collectivism scale (Hui, 1988) have been shown to differ along this variable, with the former reporting significantly more collectivistic tendencies (Shkodrianai & Gibbons, 1995). Moreover, in a study assessing cultural attitudes concerning family functioning, self-reports from 100 Mexican-American and European-American adults revealed that the former held significantly more collectivist beliefs and displayed more helping behaviors in relationships than their European-American counterparts (Freeberg & Stein, 1996). It should be noted that conflicting evidence does exist: in a meta-analysis examining within-U.S. ethnic comparisons, it was found that, while European-Americans were more individualistic than ethnic minorities as a whole, they were not significantly more so than Latino Americans; Latino Americans, however, were found to be more collectivist than European-Americans, though the aggregate effects were small (Oyserman et al., 2006).

The collectivistic nature of Latinos is theorized to be manifested in their interpersonal behaviors, particularly in the communication styles of *simpatia*, *personalismo*, and *confianza* (Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002). Though not believed to be exclusively representative of Latino individuals, these constructs are thought to play an essential role in interpersonal communications among

members of this group, and their consideration in the treatment of Latino clients has been advocated (Gloria & Peregoy, 1996).

Simpatia, or the ability to empathize, respect, and remain agreeable in interactions with others, is purported to be a characteristic of Latino interpersonal style (Comas-Diaz, 1989; Triandis et al., 1984; Valera et al., 2004); specifically, behaviors promoting pleasant social interactions are valued and interpersonal conflict is vigorously avoided. Latinas have also been said to highly regard warm, genuine, and affable individuals, encapsulated in the term *personalismo* (Cauce & Rodriguez, 2001; Comas-Diaz, 1996; Organista, 2003; Santiago-Rivera et al., 2002). In therapeutic settings, this penchant for enhanced interpersonal contact may indicate a greater emphasis on small talk and increased clinician disclosure (Paniagua, 1994). Furthermore, Latinos have been described as valuing *confianza*, or the existence of trust and intimacy in relationships (Bracero, 1998; Lewis-Fernandez & Kleinman, 1994). Thought to develop out of a relationship based on respect (or *respecto*) and *personalismo* (De Rios, 2001), *confianza* promotes increased personal comfort between members of a therapeutic alliance and has been hypothesized to lead to greater self-disclosure in many Latino patients (Santiago-Rivera et al., 2002).

Consideration of a final, related construct, *familismo*, descriptive of the increased emphasis placed on familial relationships and the needs of the collective over one's own, is thought to be related to positive clinical outcomes and, therefore, has been suggested as a factor for consideration when working with Latino clients (Anez, Paris, Bedregal, Davidson, Grilo, 2005). Behaviors representative of this cultural characteristic include

helpfulness, generosity, loyalty, and sacrifice for the benefit of the family (Antshel, 2002). Moreover, this concept is purported to reach beyond one's nuclear family, involve extended family and friends, and perhaps influence the therapist and client relationship. Awareness of this distinction may reduce feelings of alienation and increase perceptions of understanding in the client, and thus facilitating treatment goals by improving the therapeutic alliance (Anez, 2005).

Chapter Three: Proposed Research Study

Statement of the Problem

Depression during childhood and adolescence is a common and enduring disorder (Kovacs et al., 1984), with lasting repercussions throughout the lifespan (Birmaher et al., 1996; Kandel & Davies, 1986; Lewinsohn, et al., 1994a; Puig-Antich, 1985). Female rates of depression have been noted to increase during adolescence (Angold & Rutter, 1992; Costello et al., 2002), with girls becoming twice as likely as boys to suffer from depression at that time (Fleming & Offord, 1990; Fergusson et al., 1993; Klerman & Weissman, 1989). Cognitive behavioral therapy (CBT) has been shown to be an effective intervention for the treatment for early-onset depression (Asarnow, et al., 2001; Birmaher et al. 1996; Kaslow & Thompson, 1998; Kazdin & Weisz, 1998; Lewinsohn & Clark, 1999; Weersing & Weisz, 2002). Moreover, treatment effectiveness has been hypothesized to be dependent on various nonspecific therapeutic components (Hubble et al., 1999); group cohesion, specifically, has been positively correlated with reductions in depressive symptoms (Schiff et al., 2007). Furthermore, Latino youth have been found to display higher rates of depression than other youth (Kessler et al, 1994; Joiner et al., 2001; Roberts et al., 1997; Weinberg & Emslie, 1987) and the efficacy of CBT interventions with this particular population has, to some extent, been demonstrated (Rosello & Bernal, 1999; Rossello et al., 2008). In addition, research has evidenced the existence of collectivist tendencies in Latinos (Shkodrianai & Gibbons, 1995) and theories concerning its impact on these individuals' interpersonal behavior have been posited (Santiago-Rivera et al., 2002). The association between this particular

demographic factor, ethnic status, and nonspecific therapeutic factors, however, has not been adequately addressed (Johnson et al., 2005) and, the affect of group cohesion on treatment outcomes in ethnic minority youth, specifically in the context of cognitive-behavioral therapy for the treatment of depression in Latino adolescents, has yet to be investigated. Thus, the next reasonable step is a determination of the differential effects of group cohesion in changes in depressive symptoms in Latina and European-American female youth. It is hoped that this study will lead to an increased discernment in cultural sensitivity with regards to the delivery of interventions for the treatment of depression.

Statement of the Purpose

The proposed study seeks to investigate the effects of group cohesion in the context of group CBT on changes in depression symptoms in biethnic youth. First, the effect of group cohesion on changes in depressive symptoms will be explored. It is expected that group cohesion will be negatively correlated with changes in depression scores. Next, the effect of ethnicity on changes in depressive symptoms will be examined. It is hypothesized that no significant differences in changes in depressive scores will exist between the Latina and European-American girls. Finally, an interaction effect of group cohesion and ethnicity on changes in depressive symptoms will be analyzed. It is expected that higher ratings of group cohesion will be associated with greater reduction of depressive symptoms, with the effect being more pronounced in Latinas than their European-American peers.

Depression will be assessed using both the depressed child and her parent as informants on a semi-structured interview to determine the presence and severity of the

depressive disorder. Self-reports of group cohesion, averaged across studies, from these Latina and European-American girls undergoing CBT treatment for depression will be also utilized.

Research Questions and Hypotheses

Research Question 1

Does group cohesion account for a significant amount of the variance in participants' changes in depression scores?

Hypothesis 1

It is hypothesized that group cohesion will significantly account for variability in changes in depressive symptoms, while controlling pre-treatment depressive scores. As group cohesion increases, depressive symptoms are expected to decrease.

Rationale

Research suggests an existing association between group cohesion and clinical symptom reduction (Bieling et al., 2003; Budman et al., 1989; Taft et al., 2003; Tschuschke and Dies, 1994). Specifically, Hand and colleagues found treatment of agoraphobia using in-vivo exposure (flooding), a CBT technique, to be more enduringly successful in groups in which group cohesion was fostered. Moreover, Schiff and colleagues (2007) demonstrated that a time-limited group CBT for the treatment of Social Phobia was more effective in reducing symptoms in those individuals with enhanced experiences of group cohesion. Though not in the context of treatment of depressive youth, support for the consideration of nonspecific therapeutic factors in clinical treatment exists.

Research Question 2

Does ethnicity account for a significant amount of the variance in participants' changes in depression scores?

Hypothesis 2

It is hypothesized that ethnicity will not significantly account for variability in changes in depressive symptoms, while controlling for pre-treatment depression scores.

Rationale

Cognitive behavioral therapy (CBT) has been shown to be an effective intervention for the treatment for early-onset depression (Asarnow et al., 2001; Kaslow & Thompson, 1998; Kazdin & Weisz, 1998; Weersing & Weisz, 2002); large effect sizes concerning the impact of CBT for treatment of youth depression have been found (1.27, Lewinsohn & Clarke, 1999; 1.02, Reinecke et al., 1998). Moreover, it remains the only psychotherapeutic treatment to be accorded with the label "probably efficacious" (David-Ferdon & Kaslow, 2008). The majority of these studies, however, have employed limited sampling procedures, for the most part examining the efficacy of CBT treatments on European-American participants (Scott & Watkins, 2006; Weisz et al., 2005). Although lacking in extensiveness, data concerning the effectiveness of CBT in treating depressed ethnic minority exists (Araya et al, 2003; Miranda et al, 2003). With regards to minority youth, Rossello & Bernal (1999) and Rossello and colleagues (2008) found CBT to be superior to wait-list controls in treating depressive symptoms in Puerto Rican adolescents.

Research Question 3

Does group cohesion differentially affect changes in depression scores in Latina and

European-American girls?

Hypothesis 3

It is hypothesized that group cohesion will significantly affect changes in depressive symptoms more so for Latinas than for European-American girls, while controlling for pre-treatment depression scores.

Rationale

Though nonspecific therapeutic factors have shown to positively affect clinical outcomes (Bieling et al., 2003; Budman et al, 1989; Schiff et al., 2007), the data concerning the potential impact of ethnic and racial differences on these variables is limited (Johnson et al., 2005). Bernal et al. (1998), for instance, found a positive relationship between therapeutic alliance and treatment outcome in sample of Puerto Ricans. Furthermore, Rohde and colleagues (2006) have, based on a study examining demographic, psychopathological, and psychosocial factors affecting recovery time in depressed adolescents, suggested that depressed ethnic minority adolescents might benefit from an increased focus on the therapeutic relationship to a greater extent than their European-American counterparts. While the effect of group cohesion on treatment effects in ethnic minority youth, specifically in the context of cognitive-behavioral therapy for the treatment of depression in Latino adolescents, has not been investigated, elements of Latino culture, including a proclivity towards a collectivist attitude (Hofstede, 1980; Ramirez, 1990; Shkodrianai & Gibbons, 1995; Triandis et al., 1984), related interpersonal styles, involving elements of *simpatia*, *personalismo*, and *confianza*, (Santiago-Rivera et

al., 2002), and *familismo* (Anez et al., 2005), point to a potential for a greater effect of group cohesion on treatment outcomes in Latinas than in their European-American peers.

Method

This study is part of a larger research effort (ACTION).

Participants

Participants in the larger treatment group's CBT-only condition included 146 girls, aged 8 to 14 in grades 4 to 7 (4^{th}=32 girls, 5^{th}=39, 6^{th}=40, 7^{th}=35). These participants described their ethnicity as follows: 70 girls described themselves as Latina, 71 as not European-American, 3 as American-Indian/Alaska Native, and 2 as Asian-American.

Participants were included in the study if they received a primary diagnosis of Major Depressive Disorder (MDD) (n = 114), Dysthymic Disorder (n = 23), or Depressive Disorder Not Otherwise Specified (n = 9). Approximately 64% suffered from secondary disorders, including Generalized Anxiety Disorder, MDD, Dysthymia, Separation Anxiety Disorder, Post Traumatic Stress Disorder (PTSD), Specific Phobia, Anxiety Not Otherwise Specified, Attention Deficit Hyperactivity Disorder (ADHD), Parent Child Relational Problem Other, Eating Disorder, Social Phobia, and Oppositional Defiant Disorder. Participants were excluded from the study if they presented with a comorbid disorder more severe than their depressive disorder, were suicidal or homicidal, displayed psychotic symptoms, were already receiving therapeutic or pharmacological treatment for their depressive symptoms, possessed a below average IQ (< 85) or a learning disability that would preclude them from completing various measures, or

suffered from a serious disability that would inhibit them from regularly attending sessions.

The proposed study will examine group cohesion and depression scores of 141 girls, 70 and 71 of whom are Latina and European-American, respectively. Only girls participating in the CBT-only condition will be included in the proposed study.

Instrumentation

Only instruments that are relevant to the proposed study are discussed.

Measures of Depression

Children's Depression Inventory. The Children's Depression Inventory (CDI; Kovacs, 1981; see Appendix A) is the most extensively used self-report measure for the assessment of depression in youth, ages 7 to 17. Used in the present study for screening purposes, this 27-item measure, which can be administered individually or in a group format, evaluates the existence and severity of depressive symptoms over a two-week period. Three alternatives are offered for each item, resulting in total scores from 0 to 54, with higher scores indicating greater experience of depression. Severity of depression experienced by the child is considered to be significant when scores of 19 or above result based on the child's endorsements (Kovacs, 1981; Smucker, Craighead, Craighead, & Green, 1986). With regards to screening, however, scores of 16 and above are considered to have satisfactory predictive value (Timbremont, Braet, & Dreesen, 2004).

Internal consistency has been shown to range from .71 to .89 for various samples (Kovacs, 1981; Smucker et al., 1986). Test-retest reliability has varied from .38 to .87 (Kovacs, 1981); the lower values in this range may be due to the "state" (rather than a

trait) focus on the measure (Kovacs, 1992). Conflicting findings regarding the discriminant validity of the CDI have been reported, with some uncovering a low level of accurate discrimination between diagnoses (e.g., Carey, Faulstich, Gresham, & Ruggerio, 1987) and other research showing accurate diagnosis of depression 86% of the time (Timbremont et al., 2004).

Diagnostic and Statistical Manual Brief Symptom Interview for Depression. The Diagnostic and Statistical Manual Brief Symptom Interview for Depression (DSM Interview; Stark & Sander, 2002; see Appendix A) is a semi-structured interview designed for use as a screening and monitoring device. The DSM Interview concerns itself with the appraisal of the depressive symptoms and the determination of the presence of a depressive disorder, as defined by DSM-IV criteria. Symptoms are considered present if the child indicates that the particular symptom has caused them distress and has interfered with their functioning for most days in the past two weeks.

The Schedule for Affective Disorders and Schizophrenia for School Age Children. The Schedule for Affective Disorders and Schizophrenia for School Age Children (K-SADS-P IVR; Ambrosini & Dixon, 2000; see Appendix A) is a semi-structured diagnostic interview used to assess the presence of a depressive disorder in children and adolescents, aged six to 18. It is administered to both children and their parents and generates a rating that summarizes both the presence and severity of DSM-IV symptoms in six areas: major depression, mania, eating disorder, anxiety disorders, behavioral disorders, substance abuse, and psychotic disorders. Each symptom is assigned a severity rating, based on information obtained from the child and parent interviews, with the

diagnosing clinician generating a summary rating based on all gathered information; ratings range from 0 to 4 or 0 to 6, with higher scores indicating increased severity. Symptoms are deemed clinically significant if a rating of above 3 is endorsed on the 0 to 4 scale or greater than 4 on the 0 to 6 scale. Ratings are then used to determine diagnoses in relation the DSM-IV criteria.

As the K-SADS-P IVR was recently modified to be more congruent with the DSM-IV diagnostic criteria, little reliability and internal consistency data are available. Nevertheless, high inter-rater reliability was established for the diagnoses of Major Depression, Dysthymic Disorder, Generalized Anxiety Disorder, Separation Anxiety Disorder, and Oppositional Defiant Disorder (Ambrosini, 2000). For earlier versions of the K-SADS (K-SADS IIIR), high inter-rater reliability (Last & Strauss, 1990), adequate internal consistency (Ambrosini, Metz, Prabucki, & Lee, 1989), and acceptable test-retest reliability (Apter, Orvaschel, Laseg, Moses, & Tyano, 1989) have been found.

An aggregate depression score incorporating all items within the K-SADS depression interview section can also be determined (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991). This score, which ranges from 17 to 97, with higher scores indicative of greater severity, is calculated by summing the severity ratings of each of the 17 items. Adequate psychometric support, in the form of internal consistently in the .72 to .89 range (Ambrosini et al., 1991; Chambers et al., 1985), and test-retest reliability at .81 (Chambers et al., 1985), exists.

Measure of Group Cohesiveness

Group Cohesion Scale-Revised. The Group Cohesion Scale-Revised (GCS-R; Treadwell et al., 2001; see Appendix B) is a 25-item self-report measure used to assess group cohesion. Each item is rated on a 4-point Likert scale, from strongly disagree to strongly agree. Group cohesion is measured by examining interactions among group members, decision-making, vulnerability of group members, communication among group members, and consistency between group and individual goals. Internal consistency, as measured by Cronbach's alpha, has been obtained, and ranged from .49 to .89 on pre-assessment and .77 and .90 on post-assessment (Treadwell et al., 2001).

Procedure

Approval by Human Subjects committee

The original study was conducted in compliance with the ethical standards designated by the American Psychological Association, as well as the standards set forth by the University of Texas at Austin. The principal investigator secured approval from the Institutional Review Board at the University of Texas at Austin before beginning data collection.

Approval by the School District

Prior to data collection, the principal investigator submitted a written proposal to the superintendent of the selected school districts. Following the acceptance of proposals, the principal investigator met with school personnel at each individual school to answer questions regarding the proposed study.

Recruitment of Participants

Participants were informed of the study by the administrators or teachers in their elementary, middle, and high schools of the selected school district. A letter describing the proposed study and consent forms for the parent was distributed to all students in the selected schools (see Appendix C). Completed consent forms were collected by school personnel and given to the principal investigator.

Data Collection

A multi-gate assessment procedure was utilized to ensure both accurate diagnoses and efficient use of the principal investigator's time (Reynolds, 1986). Children who returned signed parental consent forms were asked to sign child assent forms. Next, participants were given the CDI to complete; if scores of 16 or above were obtained, DSM interviews were conducted by a graduate research assistant determined whether the symptoms were severe enough to consider diagnosis with the use of K-SADS-P IVR. If they were, interviews of the child and at least one parent/guardian were undertaken. If DSM-IV criteria for the diagnosis of a depressive disorder were met, the youth were asked to participate in the present study. Participants were randomly assigned to one of the three following conditions: Cognitive-Behavioral Therapy-only, Cognitive-Behavioral Therapy-plus parent training, or Minimal Contact Control group. Girls assigned to active treatment conditions were treated in groups of three to five.

Self-report measures and a semi-structured interview, conducted following the successful completion of the treatment, provided evidence for the treatment's effect. At the conclusion of each session, participants provided information regarding their experience of group cohesion via an additional self-report measure, described above.

Training of Measures Administrators, Interviewers, and Therapists

Doctoral level students were trained in the administration and scoring of measure, with special focus dedicated to the assessment of suicidal ideation and intent.

Doctoral level students who were further along in their academic training (i.e., at a minimum, had been exposed to program coursework in child psychopathology and diagnostic case formulations) were trained, over the period of six months, in the administration of the K-SADS-IVR interview. Training consisted of reviewing tapes of previously conducted interviews and live observation of K-SADS-IVR interviews, following which supervised practice with volunteers was undertaken, for which the interviewer received personal feedback.

Over a six-month period, advanced doctoral psychology students were trained in the implementation of CBT to conduct therapy sessions autonomously. Specifically, after having received didactic training focused on the treatment manual, therapeutic techniques, and practical issues, trainees observed an experienced therapist administer the entire treatment to a group of girls. Following this experience, trainees co-led a group under the supervision of a senior therapist. Individual supervision from both the principal investigator and the co-therapist was provided to therapists-in-training on a weekly basis; bimonthly group supervision meetings also complemented these individual sessions. Once having completed this training, therapists will be permitted to lead a group independently, though while continuing to be present at individual weekly supervision session with the project's principal investigator and bi-monthly group supervision

meetings. In all, 150 hours of training occurred prior to the therapist being allowed to independently implement the treatment protocol

Data Analyses and Expected Results

The primary purpose of this study will be to examine whether group cohesion ratings better explain the variability in changes in depressive symptoms exhibited by Latinas than in European-American girls. Data including K-SADS aggregate depression scores, group cohesion self-report ratings averaged across sessions, and ethnic status, will be analyzed using multiple regression analyses. A sequential, or hierarchical, multiple regression model, controlling for pre-treatment depression scores and including a group cohesion factor, an ethnicity factor, and a group cohesion and ethnicity interaction factor, in the order listed here, will be used.

Preliminary Analyses

In order to ensure compliance with the requirements of multiple regression, preliminary analyses will be conducted. Prior to testing the research hypotheses using multiple regression analysis, descriptive statistics, including means, standard deviations, ranges, and minimum and maximum values, will be calculated and analyzed. Linearity will be checked by inspecting scatterplots of the data, and a plot of the residuals against the predicted values will be examined to confirm the presence of normally distributed residuals. Additionally, sensitivity analyses will determine the effect of outliers. In addition, tests of multicollinearity will be conducted, and group cohesion will be centered in order to reduce potential multicolinearity.

A power analysis was conducted using G-POWER software, version 3, to determine the

approximate number of participants required to obtain a statistically significant finding in the proposed study. An overall model R^2 of .10, with four independent variables, was used in order to determine sample size. It was determined that a sample size of 113 was adequate to achieve 80% power. As such, a sample size of 141 girls (70 Latinas and 71 European-American) will be included in the present study.

Tests of Research Questions

An alpha level of .05 will be implemented for all analyses within this section.

Hypothesis 1

It is hypothesized that group cohesion will explain a significant amount of the variability in depressive symptoms, after controlling for pre-treatment depression scores. In this model, the participant's change in depressive symptoms, as measured by the difference between K-SADS summary scores at pre- and post-treatment, will be regressed onto group cohesion scores using sequential multiple regression. It is expected that group cohesion will explain a statistically significant amount of variance in changes in depression scores. In other words, increased group cohesion will explain an improvement in depressive symptoms.

Hypothesis 2

It is hypothesized that ethnicity will not explain a significant amount of variability in depressive symptoms, after controlling for pre-treatment depression scores. In this model, the changes in participant's depressive symptoms, as measured by the difference between K-SADS summary scores at pre- and post-treatment, will be regressed onto ethnicity using sequential multiple regression. Put differently, no significant differences in

depressive scores will exist between the Latina and European-American girls.

Hypothesis 3

It is hypothesized that group cohesion and ethnicity will interact to explain changes in participants' depressive symptoms. A group cohesion and ethnicity interaction will be added to the regression equation. A statistically significant increase in the change in R-square for the interaction will suggest a statistically significant interaction between the variables; a statistically non-significant increase in the change in R-square for the interaction will suggest a statistically insignificant interaction between the variables. It is expected that increases in group cohesion will explain changes in depressive symptoms to a greater extent in Latinas than in European-American girls. The finding of a statistically significant interaction will be probed in order to understand the nature of the interaction.

Chapter Four: Discussion

Summary and Limitations

The proposed study seeks to assess the association between nonspecific therapeutic factors, specifically group cohesion, ethnic status, and clinical outcomes following treatment of depression using cognitive-behavioral therapy in adolescent females. It is that expected that enhanced experiences of group cohesion will be correlated with greater reductions of depressive symptoms, with the effect being more pronounced in Latinas than their European-American peers.

While reductions in depressive symptoms may, as hypothesized, be associated with increases in cohesiveness between group members, other plausible factors may contribute to any observed change in depression scores. Improvements in depression may result from the girls' participation in the general CBT intervention; symptom remission or a lessening of their severity may also occur as a consequence of the natural progression of time. As such, controlling for cognitive restructuring and behavioral changes occurring as a result of participation in a CBT treatment may provide a better understanding of the mechanisms of change associated with positive clinical outcomes.

Moreover, the method of assessing group cohesion may also be of concern. Specifically, as the proposed study utilizes self-reports to measure this construct, compiling data from the duration of the treatment process, it is the girls' perceptions of group cohesion rather than its actual presence that is being assessed. Addition of objective, independent observer ratings may provide a broader, and perhaps more accurate, representation of this construct.

Additional limitations concern the makeup of the groups themselves. As girls are randomly assigned to treatment groups of three to five individuals, irrespective of their ethnic status, groups with differing demographic divisions will result, with certain ethnic groups being overly or inadequately represented. It is possible, and even probable, that the group members' ethnicities contribute to personal perceptions of group cohesion. Evident also is the exclusion of other ethnic minorities from these analyses, as Latinas and European-American girls constituted the majority of the participants included in the original study. Further research could examine the impact of nonspecific treatment factors, particularly group cohesion, on treatment outcomes in African-American, Asian-American, and various other ethnic minority youth. Correspondingly, while the particularly gender- and age-demographic sample was selected based on recommendations from the literature, a more complex design including both boys and girls across a wider age range would allow for the determination of the differential effect of group cohesion and clinical outcomes in these groups.

Finally, a further avenue of inquiry may involve assessing the relationship between group cohesion in the CBT plus family training condition and parents' subsequent perception of reductions in depressive symptoms in depressed female participants. This issue may be especially salient in groups with less acculturated or recently immigrated Latino parents, as cultural interpersonal skills could be hypothesized to have an even greater effect.

Implications

As childhood and adolescent depression are significant health concerns associated

with enduring deleterious consequences, a continued examination the mechanisms of change associated with their successful treatment is warranted. By highlighting the relationship between group cohesion, patients' ethnic status, and childhood depression, future clinicians will gain insight into the suggested treatment focus when working with these specific populations.

Significant results would lend additional support for the focus on nonspecific therapeutic components in the treatment of childhood and adolescent depression. Moreover, significant results would also prompt a conceptualization of treatment, in terms of nonspecific therapeutic processes as contributors to positive clinical outcomes, differentially considered and adapted for use with ethnically diverse youth.

Further psychometric support for the use of the Group Cohesion Scale – Revised would be garnered through this study, endorsing its use in future research investigating the impact of group cohesion on treatment outcomes.

Appendix A

Children's Depression Inventory (CDI)

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one that describes you **best** for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you been recently. Put a mark like this X next to your answer. Put the mark in the box next to the sentence you pick.

1. I am sad once in a while.
   I am sad many times.
   I am sad all the time.

2. Nothing will ever work out for me.
   I am not sure if things will work out for me.
   Things will work out for me O.K.

3. I do most things O.K.
   I do many things wrong.
   I do everything wrong.

4. I have fun in many things.
   I have fun in some things.
   Nothing is fun at all.

5. I am bad all the time.
   I am bad many times.
   I am bad once in a while.

6. I think about bad things happening to me once in a while.
   I worry that bad things will happen to me.
   I am sure that terrible things will happen to me.

7. I hate myself.
   I do not like myself.
   I like myself.

8. All bad things are my fault.
   Many bad things are my fault.

Bad things are not usually my fault.

9. I do not think about killing myself.
   I think about killing myself but I would not do it.
   I want to kill myself

10. I feel like crying every day.
    I feel like crying many days.
    I feel like crying once in a while.

11. Things bother me all the time.
    Things bother me many times.
    Things bother me once in a while.

12. I like being with people.
    I do not like being with people many times.
    I do not want to be with people at all.

13. I cannot make up my mind about things.
    It is hard to make up my mind about things.
    I make up my mind about things easily.

14. I look O.K.
    There are some bad things about my looks.
    I look ugly.

15. I have to push myself all the time to do my schoolwork.
    I have to push myself many times to do my schoolwork.
    Doing schoolwork is not a big problem.

16. I have trouble sleeping every night.
    I have trouble sleeping many nights.
    I sleep pretty well.

17. I am tired once in a while.
    I am tired many days.
    I am tired all the time.

18. Most days I do not feel like eating.
    Many days I do not feel like eating.
    I eat pretty well.

19. I do not worry about aches and pains.
    I worry about aches and pains many times.

I worry about aches and pains all the time.

20. I do not feel alone.
    I feel alone many times.
    I feel alone all the time.

21. I never have fun at school.
    I have fun at school only once in a while.
    I have fun at school many times.

22. I have plenty of friends.
    I have some friends but I wish I had more.
    I do not have any friends.

23. My schoolwork is alright.
    My schoolwork is not as good as before.
    I do very badly in subjects I used to be good in.

24. I can never be as good as other kids.
    I can be as good as other kids if I want to.
    I am just as good as other kids.

25. Nobody really loves me.
    I am not sure if anybody loves me.
    I am sure that somebody loves me.

26. I usually do what I am told.
    I do not do what I am told most of the times.
    I never do what I am told.

27. I get along with people.
    I get into fights many times.
    I get into fights all the time.

Appendix B

Diagnostic and Statistical Manual Brief Symptom Interview for Depression (DSM - Interview)

Symptoms: Ask about symptoms being present most days for THE LAST TWO WEEKS, INCLUDING TODAY.	**Symptom IS present (√)**	**Symptom NOT present (√)**
1. Have you been feeling sad, unhappy, blue, or down in the dumps for a lot of the day?	❒	❒
2. Have you been feeling irritable, cranky, or easily annoyed for a lot of the day	❒	❒
3. Have you been less interested in doing things like hobbies or sports?	❒	❒
4. Have you been enjoying hobbies or interests less that you did in the past?	❒	❒
5. Have you noticed a change in your appetite (eating more or less than usual)? Has your weight changed or do your clothes fit differently?	❒	❒
6. Have you had any trouble with your sleep, such as falling asleep, waking up at night, or waking too early?	❒	❒
7. Have you been having trouble with your sleep, in that you are sleeping a lot more than usual lately?	❒	❒
8. Do you feel like you still need sleep or rest, even if you got a full night's sleep?	❒	❒
9. Do you feel like you have no energy, or not as much energy as usual?	❒	❒
10. Do you feel restless or fidgety, that you have a hard time sitting still?	❒	❒
11. Have you felt slowed down, like you are moving in slow motion or your movements are not as quick as usual?	❒	❒
12. Have you had trouble concentrating or paying attention, like your mind is "in a fog?" Or trouble making decisions?	❒	❒
13. Have you felt guilty about things lately?	❒	❒
14. Have you felt hopeless, like things won't work out for you, or that you will always feel bad?	❒	❒
15. Have you felt worthless, inadequate, or like you are no good lately?	❒	❒
16. Have you had thoughts of death or dying?	❒	❒
17. Have you had thoughts of wanting to hurt yourself? (or someone else)	❒	❒

18. Have you done anything to hurt yourself, such as make a mark on your skin?	❒	❒

TOTAL "PRESENT" Items 1-18

Appendix C

The Schedule for Affective Disorders and Schizophrenia for School-Age Children
Present State (KSADS-P IVR)
(Selected Portion of the Depressive Disorders Section)

HAM-D (Depressed Mood) (01)

0 -- Absent
1 -- These feeling states indicated only on questioning
2 -- These feeling states spontaneously reported verbally
3 -- Communicates feeling states non-verbally - ie, through facial expression, posture, voice, and tendency to weep
4 -- VIRTUALLY ONLY these feeling states are evident from spontaneous verbal and nonverbal communication

What's your mood been like this past week?

- Have you been feeling down or depressed?
- Sad? Hopelessness?
- In the past week, how often have you felt (USE PATIENT TERM)? Every day? All day?
- Have you been crying at all?
  If scored 1 - 4, ask to establish duration.
- How long have you been feeling this way?

DEPRESSED MOOD

Refers to subjective feelings of depression based on verbal complaints of feeling depressed, sad, blue, gloomy, very unhappy, down, empty, bad feelings, feels like crying. Some children will deny feeling "sad" and report feeling only "bad", so it is important to inquire specifically about each dysphoric affect. In the interview with parent(s), mother's "gut feeling" (empathic sensing) that the child frequently feels depressed can be taken as positive evidence of child's depressive mood if parent is not concurrently depressed. IRRITABILITY WITHOUT ANY OTHER PERSISTENT DYSPHORIC AFFECT SHOULD NOT BE RATED HERE. Do not include ideational items, e.g., discouragement, pessimism, worthlessness, nor suicidal attempts, depressed appearance, nor feelings of anxiety, tension, panic or anger.

If child initially denies **DEPRESSED MOOD** but becomes obviously sad as the interview progresses, repeat item questions pointing out the child's present mood, and use it as an example to determine its frequency. Similarly, if the mother reports the child as sad most of the time and the child denies it, confront the child with the mother's opinion, e.g., ask why he thinks his mother believes he feels sad so frequently.

When a parent reports frequent short periods of sadness throughout the day, it is likely the child is often sad and only reports the exacerbations. Thus, it is always essential to ask about the rest of the time. Ratings are based on the total daily time the child feels depressed. So, one might ask, "Besides these times you feel ( ), during the rest of the day do you feel happy, or are you sad but it's not so bad? If you add up all the time each day you feel either ( ) or ( ) or ( ), how much of the day is that?"

NOTE: If parent only reports child looks sad but no other characteristics of depressed mood, rate **DEPRESSED MOOD** no greater than a 3 if sad look is persistent all day.

0 -- No info.
1 -- Not at all or less.
2 -- Slight: occasionally has dysphoric mood at least once a week for more than one hour.
3 -- Mild: sometimes experiences dysphoric mood at least 3 times week for at least 3 hours total time each day. Looks sad all the time.
4 -- Moderate: often feels "depressed" (including weekends) or over 50% of awake time.
5 -- Severe: most of the time feels depressed, and it is almost painful; feels wretched and miserable.
6 -- Extreme: almost all of the time feels extremely depressed which “I can’t stand.”
7 -- Pervasive: constant unrelieved, extremely painful feelings of depression.

- How have you been feeling?
- Have you felt sad, blue, moody, down in the dumps, very unhappy, empty, like crying? (ASK EACH ONE.)
- Have you had any other bad feelings?
- Do you have a bad feeling all the time that you can't get rid of?
- Have you cried or been tearful?
- Do you feel ( ) all the time, most of the time, some of the time? (Percent of awake time: summation of % of all labels if they do not occur simultaneously.)
- Does it come and go? How frequently?
- Every day?
- How long does it last? All day?
- Does it get so bad you feel wretched and miserable?
- Can you stand it? What do you do when you can't stand it?
- Do you feel sad when mother is away? IF SEPARATION FROM MOTHER IS GIVEN AS A CAUSE: Do you feel ( ) when mother is with you? Do you feel a little better or is the feeling totally gone? Can other people tell when you are sad? How can they tell? Do you look different?

Appendix D

Group Cohesion Scale-Revised (GCS-R)

The following items are about your perception of your group's development at this time. Rate each item on the four-point scale provided below by filling in the "bubble sheet" according to the corresponding letter. Remember that there are no right or wrong answers. We are interested in your perception of the group's functioning.

These items are to be rated on a 1 to 4 point scale

1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

_____1. Group members are accepting of variations in each other's culture, customs, habits, and traditions.

_____2. There are positive relationships among the group members.

_____3. There is a feeling of unity and togetherness among group members.

_____4. Group members usually feel free to share information.

_____5. Problem solving processes would be disrupted if one or two members are absent.

_____6. The group members feel comfortable in expressing disagreements in the group.

_____7. Problem solving in this group is truly a group effort.

_____8. Group members influence one another.

_____9. I dislike going this group's meetings.

_____10. The group members seem to be aware of the group's unspoken rules.

_____11. Discussions appear to be unrelated to the concerns of the group members.

_____12. Most group members contribute to decision making in this group.

_____13. Group members are receptive to feedback and criticism.
_____14. Despite group tensions, members tend to stick together.

_____15. It appears that the individual and group goals are inconsistent.

_____16. An unhealthy competitive attitude appears to be present among group members.

_____17. Group members usually feel free to share their opinions.

_____18. Minimal attempts are made to include quieter members of this group.

_____19. Group members respect the agreement of confidentiality.

_____20. People would be concerned when a group member is absent from the groups members.

_____21. Group members would <u>not</u> like to postpone group meetings.

_____22. Many members engage in "back-stabbing" in this group.

_____23. Group members usually feel free to share their feelings.

_____24. If a group with the same goals is formed, I would prefer to shift to that group.

_____25. I feel vulnerable in this group.

Appendix E

Parent Consent Letter for Screening

Dear Parent,

[Insert name of school here] is teaming up with Kevin Stark, Ph.D. from the University of Texas to evaluate a coping skills training program for girls called ACTION. The ACTION program is designed to teach girls how to manage their emotions and stress, solve problems, and think more positively about themselves. While we believe that all students could benefit from this program, currently, only girls who are experiencing high levels of distress will be able to participate. We are asking for permission from all parents of girls in grades [insert grade numbers of school here] for their daughters to participate in a screening that will help identify girls who are experiencing distress. Girls who participate in the screening will fill out a questionnaire that takes approximately 10 minutes to complete. Doctoral psychology students with appropriate training will supervise the completion of the questionnaires. At this time we do not anticipate any discomfort in completing the ACTION questionnaire.

Girls who report having more than a typical number symptoms of distress will be interviewed about specific symptoms of depression to determine if they are experiencing high levels of distress. The brief symptom interview will be conducted by trained graduate students or project staff under the supervision of Dr. Stark. If a girl in the study is reporting distress on the questionnaire or brief symptom interview, the parents will be contacted by phone to ensure the girl's well-being. ACTION staff or the school counselor may discuss your child's further participation in this research project at that time. For all girls who complete the questionnaire or interview and do not show significant symptoms of distress, parents will receive a letter stating those findings.

The purpose of the project is to determine whether the ACTION coping skills program is more effective than no counseling, and whether parent participation makes the program more effective. In addition, we are trying to learn whether adding follow-up meetings prevents future distress. The benefits to participants include possible participation in the ACTION program and helping advance our understanding of how to best help young girls manage emotions and stress, solve problems and feel better about themselves.

Participation in the project will not cost you anything and there will not be any financial compensation for participation. There are not any risks of harm from completing the questionnaire. There are no anticipated risks from completing the brief symptom interview. In fact, the procedure is designed to quickly identify and assist children who are in distress. All materials and forms will be stored in locked file cabinets in a secure office at UT to protect confidentiality.

If a child reports that she is at risk of hurting herself or others, her parents would be immediately informed and she would immediately talk with her school counselor. In addition, she would be evaluated by one of the consulting psychiatrists at no cost to the family.

If you choose to participate, you or your daughter may stop participation at any time. Participation in the study is entirely voluntary. You are free to say that you do not want to participate by returning this form indicating on the back of this page that you do not want to participate. You can refuse to participate without penalty or loss of benefits to which you and your daughter are otherwise entitled. It will not affect your relationship with your child's school or the University of Texas.

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child completes the screening questionnaire or interview and is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have any questions about the study, you can call Kevin Stark, Ph.D. at (512) 471-0267, your school counselor, or principal.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-8871.

Sincerely,

_____

Researcher's Signature

_____

Principal's Signature

_____

Date

PLEASE KEEP THIS LETTER FOR YOUR RECORDS

PARENT/GUARDIAN SCREENING PROCEDURE CONSENT

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for your daughter to participate in the ACTION project at your child's school by completing the screening questionnaire and brief symptom interview, or **NO**, you have read this letter and you do not want your daughter to complete the questionnaire or interview. Regardless of your decision, please sign this form and return it to your child's teacher.

PLEASE RETURN THIS FORM TO YOUR CHILD'S SCHOOL WITH YOUR PREFERENCE NOTED BELOW:

_____**YES** I **give my permission** for my daughter to participate by completing the screening questionnaire and brief symptom interview.

_____**NO** I **do not give my permission** for my daughter to participate by completing the screening questionnaire or brief symptom interview

_____ _____

Parent's Signature Date

_____

Child's Name (please print)

We will provide feedback for all participants. Please provide information below if your child will be participating.

Parent/adult guardian name(s): _____

Mailing address: _____ City/ZIP:_____

Parent phone number(s) in case we need to reach you with a concern about your child:

Home_____cell_____work_____

Appendix F

Youth Assent Form for Screening

I agree to complete a questionnaire about my thoughts, feelings, and behaviors. This questionnaire has been explained to my parent or guardian and he or she has given permission for me to participate. I may decide at any time that I do not wish to participate and that it will be stopped if I say so. My specific responses will not be shared with anyone. However, general information about how I am doing and feeling may be shared with my parent.

When I sign my name to this page I am indicating that I read this page and that I am agreeing to participate.

_____ _____

Your Signature Date

_____

Please Print your Name

Date of Birth _____

Month Day Year

Appendix G

Parent Consent Form for K-SADS

Dear Parent,

Per our contact with you regarding your daughter's responses to the screening questionnaire and brief symptom interview, we are requesting permission for you and your daughter to complete a more comprehensive interview that will help us determine more accurately whether she is experiencing serious emotional concerns or whether she was not feeling well on the days that she completed the questionnaire and brief interview. The interviews will be conducted by trained doctoral psychology students under the supervision of Kevin Stark, Ph.D., licensed psychologist. The interview of your daughter will be completed in a room at school that will protect her privacy. It takes 45 to 90 minutes to complete and asks specific questions about how your daughter is feeling, thinking and behaving and a range of experiences she may have encountered. The interview with you will cover the same topics and can be conducted in person or over the phone if that is preferable, at a time that is convenient for you. Participation in the interview will not cost you anything and there will not be any financial compensation for participation. Completed interviews will be stored in locked file cabinets in a secure office at UT to protect confidentiality. If she is, she may be eligible for participating in the ACTION program. If this wouldn't be the best program for her, we will provide you with possible resources from within the school and the community.

If a child reports that she is at risk of hurting herself or others, her parents would be immediately informed and she would immediately talk to her school counselor. In addition, she would be interviewed by Kevin Stark, Ph.D., a licensed psychologist, or one of the consulting psychiatrists at no cost to the family. If a child reports that she is being hurt, the school's standard procedures for reporting such instances to the relevant state agency would be followed.

The purpose of the project is to determine whether the ACTION coping skills program is helpful, and whether parent participation makes the program more effective. In addition, we are trying to learn whether adding follow-up meetings prevents future distress. If you have any questions about the study, you can call Kevin Stark, Ph.D. at (512) 471-0267 your school counselor, or principal.

If you choose to participate, you or your daughter may stop participation at any time. Participation in the study is entirely voluntary. You are free to say that you do not want to participate by returning this form indicating that you do not want to participate. You can refuse to participate and this decision will not affect your relationship with your child's school or the University of Texas.

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child completes the screening questionnaire or interview and is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512-471-8871). Let him know that you are enquiring about the study entitled "Helpfulness of the ACTION Coping Skills Program with and Without Parent Participation."

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for you and your daughter to participate by completing the interview, or **NO** you do not want to complete the interview nor do you want your daughter to complete the interview. Regardless of your decision, please sign this form and return it to your child's teacher. You will be given a copy of this permission letter to keep for your records.

☐ **YES** I give my permission for my daughter and I to participate by completing the interview.

☐ **NO** I do not give my permission for my daughter and I to participate by completing the interview.

_____ _____

Parent's Signature Date

_____ _____

Researcher's Signature Date

_____ _____

Principal's Signature Date

Appendix H

Youth Assent Form for K-SADS; Depressed Group

I agree to participate in an interview about my thoughts, feelings, and behaviors. It has been explained to me that this interview will help to determine whether the ACTIION counseling program may be helpful for me. This interview has been explained to my parent or guardian and he or she has given permission for me to participate. The interview will be stopped if I say so. Specific things that I say during the interview will not be shared with anyone. However, general information about how I am doing and feeling may be shared with my parent for the sake of talking about what to do to help me.

I will be asked to complete an interview about my current feelings, behaviors, and thoughts. By signing this form I am giving permission for the interview to be audio-taped for the purpose of being sure that the interview was conducted correctly. These tapes will be erased as soon as the ACTION program is completed.

It is okay if I decide to stop my participation in this interview at any time. When I sign my name to this page I am indicating that this page was read to me and that I am agreeing to participate.

Child/Adolescent Signature	Date
Staff/Researcher Signature	Date

Appendix I

Parent Consent for Pre-treatment Assessment and Treatment

Dear Parent,

Based on results of the screening and interview that you and your daughter have participated in so far, we are requesting permission for you and your daughter to continue and participate in the evaluation of the ACTION coping skills program. If you give your permission for your daughter to participate, she will be randomly assigned to one of three groups: (1) ACTION coping skills program, (2) ACTION coping skills program plus parent participation, or (3) wait to receive the program in about 12 weeks.

If your daughter is randomly assigned to the ACTION coping skills program, she will meet 20 times over the next twelve to sixteen weeks with a group of girls to participate in a counseling program that is designed to teach her problem solving, coping skills for managing her emotions and stress, and strategies for thinking more positively about herself and things in general.

If your daughter is randomly assigned to the counseling plus parent participation, she will meet 20 times over the next twelve to sixteen weeks with a group of girls to participate in a counseling program that is designed to teach her problem solving, coping skills for managing her emotions and stress, and strategies for thinking more positively about herself and things in general. In addition, you would be asked to attend a total of 10 meetings over this period that will last about an hour and a half. The parent meetings will be held at school after hours and daycare and refreshments will be provided at no expense. During these meetings parents will have a chance to learn the skills that their daughter is learning, and parents will learn strategies for helping their daughter to use the skills.

The girls will meet in a small group during an elective class. Each meeting will last one class period. Steps have already been taken to ensure that she will receive any class materials that she misses. The group meetings will be led by a trained doctoral psychology student or Ph.D. level therapist and a counselor from your daughter's school. The group leaders will be supervised by Kevin Stark, Ph.D. It is not expected that your daughter will experience any discomfort or risks from participating in the ACTION coping skills program. In fact, past experience with the program indicates that the girls enjoy participating and benefit from it.

If your daughter is randomly assigned to wait to receive counseling in about 12 weeks, we will take the following steps to ensure that she is okay. A doctoral psychology student will meet with her each week to monitor how she is doing, she will be discreetly observed in school at lunch or recess for about fifteen minutes per week, and the staff member will check-in with her teacher each week. In addition, every other week, the staff member will check with you to see if you have any concerns. At the end of the waiting period, she will

have the opportunity to participate in the coping skills program. If at any point during this waiting period she reports feeling worse or you would like to seek counseling elsewhere, we will provide you with information about community and school resources. You have the option at anytime to seek additional services including consultation with one of the project's consulting psychiatrists at no cost to you.

We will be monitoring each girl's progress and report this information to two psychiatrists who are being paid by us to oversee each child's welfare. If a participant is not improving as a result of the program, then parents will be informed and we will meet with you to discuss other options for providing your daughter with help. If you would like information about medications that might be of assistance, the psychiatrists are available to meet with you and discuss these options at no cost to you.

To determine whether the ACTION coping skills program is helpful, we are asking you and your daughter to complete some questionnaires that help guide, and evaluate the effectiveness of the ACTION program. The questionnaires will take your daughter about one hour to complete. It will take you about 30 minutes to complete your questionnaires. We are asking you to complete the questionnaires so that we can determine whether participation in the ACTION program also benefits you and your family. The questionnaires have been completed by other children and adults without any discomfort. In order to assess the potential benefits of ACTION on school performance, our staff collects the following general education information: grades from reporting periods, attendance, and discipline information for participants.

For one year after completion of the ACTION program, your daughter will have the opportunity to meet with her group and apply the skills to the new problems and stresses that she faces as she grows up and navigates her way through the many difficulties of being a teenager. The groups will meet three times a semester over the rest of the course of the study. In addition, to determine if your daughter needs additional help, once a year, we will ask you and your daughter to complete the interview and the questionnaires to determine whether we have achieved the goal of preventing the difficulties from recurring. Each time in the future that you and your daughter are asked to complete the measures, you will be paid $25.00 and your daughter will be paid $20.00.

If a participant reports at any time that she is feeling like she would like to hurt herself or someone else, then, she would be immediately interviewed by a trained staff member and the school counselor. In addition, if there is concern about a child's safety, the staff member would immediately contact the parents and Kevin Stark, Ph.D. or one of the consulting psychiatrists. If at all possible, the psychiatrist on call would be available to meet with the girl and her parents to further evaluate the situation and to provide you with information about resources from within the community that could be of help. If it is not possible to immediately meet with one of the mental health professionals, then it would be recommended that the child and parents pursue the conventional procedure of driving to the emergency room of a local hospital. If a participant reports that she is being hurt, then the

staff member and school counselor would follow the school's standard procedures for reporting such instances to the relevant state agency.

All of the services that we provide are available to you at no cost to your family.

The benefits to you and your daughter are that she may learn skills and strategies that will help her to be happy and healthy throughout adolescence. Similarly, you may learn strategies for helping her to successfully make it through adolescence. The benefit to society is that it will help us to determine whether teaching girls who are experiencing depression these skills helps to reduce the depression and whether it is even more helpful to involve parents. Furthermore, since girls are at very high risk for becoming depressed between the ages of 13 to 15, the results of this study will help us learn whether there is a procedure for preventing this from occurring.

The ACTION program meetings are audiotaped for quality assurance purposes. To ensure confidentiality, the following steps will be taken: (a) the cassettes will be coded so that no personal identifying information is visible on them; (b) they will be kept in a locked file cabinet in a secure office at UT; (c) they will be reviewed only for research purposes by the relevant research staff; and (d) they will be erased after they are checked and the study has been completed. Identifying information will be removed from all of the assessment materials completed during the study and the materials will be stored in a locked file cabinet in a locked research office at UT.

Participation in the ACTION coping skills program is entirely voluntary. You are free to refuse to be in the study, you are free to discontinue participation for any reason at any time, and your refusal or discontinuation will not influence current or future relationships with The University of Texas at Austin or your child's school district

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have any questions about the study, concerns, or to withdraw from the study, you can call Kevin Stark, Ph.D. at (512) 471-4407, your school counselor, or principal.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-8871. Let her know that you are enquiring

about the study entitled "Helpfulness of the ACTION Coping Skills Program with and Without Parent Participation."

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for you and your daughter to participate in the ACTION coping skills program and to complete the questionnaires, or **NO** you do not want to participate in the ACTION coping skills program and you do not want to complete the questionnaires. Regardless of your decision, please sign this form and return it to your child's counselor. With this permission letter, you should have received a copy to keep for your records.

NOTE: TWO COPIES OF THIS LETTER ARE PROVIDED; ONE IS TO KEEP FOR YOUR RECORDS

PLEASE RETURN ONE COPY OF THIS PORTION TO THE SCHOOL COUNSELOR

☐ **YES** I give my permission for my daughter, _____, and me to participate in the ACTION coping skills program and to complete the questionnaires. This includes permission for ACTION staff to access report card information, discipline referrals, and attendance records during participation.

☐ **NO** I do not give my permission for my daughter, _____, to continue any further with the ACTION project.

_____ _____

Parent's Signature Date

_____ _____

Kevin D. Stark, Ph.D. Date

NOTE: TWO COPIES OF THIS LETTER ARE PROVIDED; ONE IS TO KEEP FOR

YOUR RECORDS

*****PLEASE RETURN THIS FORM TO YOUR SCHOOL COUNSELOR*****

Appendix J

Child/Adolescent Assent Form

I agree to participate in a study that is interested in evaluating the relationship between thoughts, feelings, and interpersonal behaviors in children and adolescents. I understand that this study has been explained to my parent or guardian and that he or she has given permission for me to participate. I understand that I may decide at any time that I do not wish to continue this study and that it will be stopped if I say so. Information about what I say and do will not be given to anyone else unless I say so.

I understand that I will be asked to complete an interview about my current feelings, behaviors, and thoughts as well as a number of questionnaires about myself and my family. I understand that by signing this form I am giving permission for the interview to be audio-taped for research purposes and that these tapes will be erased as soon as the study is completed.

I understand that it is all right if I decide to stop my participation in this study at any time. When I sign my name to this page I am indicating that this page was read to me and that I am agreeing to participate in this study. I am indicating that I understand what will be required of me and that I may stop my participation at any time.

_____ _____

Child/Adolescent Signature Date

_____ _____

Staff/Researcher Signature Date

References

Abela, J. R. Z., & Hankin, B. L. (2008). *Handbook of depression in children and adolescents*. New York: The Guilford Press.

Abramson, L.Y., Metalsky, G.I., & Alloy, L.B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review, 96,* 358-372.

Abramson, L.Y., Seligman, M. E., & Teasdale, J.D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, *87(1),* 49-74.

Ambrosini, P.J. (2000). Historical development and present status of the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS). *Journal of the American Academy of Child & Adolescent Psychiatry, 39(1)*, 49-58.

Ambrosini, P.J. & Dixon, J.F. (2000). *Schedule for affective disorders & schizophrenia for school age children (6-18 years) – Kiddie-SADS (KSADS) (present state and lifetime version) K-SADS-IVR (Revision of K-SADS-IIIR)*. Unpublished manuscript. Eastern Pennsylvania Psychiatric Institute, Philadelphia, PA.

Ambrosini, P.J., Metz, C., Bianchi, M.D., Rabinovich, H., & Undie, A. (1991). Concurrent validity and psychometric properties of the Beck Depression Inventory in outpatient adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 30(1)*, 51-57.

Ambrosini, P.J., Metz, C., Prabucki, K., & Lee, J. (1989). Videotape reliability of the third revised edition of the KSADS. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 723-728.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorder* (4th ed. TR). Washington, D.C.: Author.

Angold, A. & Rutter, M. (1992). Effects of age and pubertal status on depression in a large clinical sample. *Development and Psychopathology, 4(1),* 5-28.

Angold, A., Weissman, M. M., John, K., Merikancas, K. R., Prusoff, B. A., Wickramaratne, P., Gammon, G. D., & Warner, V. (1987). Parent and child reports of depressive symptoms in children at low and high risk of depression. *Journal of Child Psychology and Psychiatry, 28(6).* 901-915.

Anez, L.M., Paris, M., Bedregal, L.E., Davidson, L., & Grilo, C.M. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Practice, 11(4),* 221-230.

Antshel, K.M. (2002). Integrating culture as a means of improving treatment adherence in the Latino population. *Psychology, Health, & Medicine, 7,* 436-449.

Apter, A., Orvaschel, H., Laseg, M., Moses, T., & Tyano, S. (1989). Psychometric properties of the K-SADS-P in an Israeli adolescent inpatient population. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 61-65.

Araya, R., Rojas, G., Fritsch, R., Gaeta, J., Rojas, M., Simon, G., et al. (2003). Treating depression in primary care in low-income women in Santiago, Chile: a randomized controlled trial. *Lancet, 361,* 995–1000.

Asarnow, J.R., Jaycox, L.H., & Tompson, M.C. (2001). Depression in youth: Psychosocial Interventions. *Journal of Child Clinical Psychology, 30*, 33-47.

Bavington, J. & Majid, A. (1986) Psychiatric services for ethnic minority groups. In J.L.

Cox (Ed.), *Transcultural Psychiatry.* London: Croom Helm.

Beck, A.T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Hoeber.

Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.

Beck, A.T., Shaw, B.F., Rush, A.J., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Bednar, R., & Kaul, T. (1994). Experiential group research: Can the canon fire? In A. E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 631-663). New York: Wiley.

Bernal, G., Bonilla, J., Padilla-Cotto, L., & Perez-Prado, E.M. (1998). Factors associated to outcome in psychotherapy : An effectiveness study in Puerto Rico. *Journal of Clinical Psychology, 54(3),* 329-342.

Bhugra, D., & Bhui, K. (1998). Psychotherapy for ethnic minorities: Issues, context and practice. *British Journal of Psychotherapy, 14(3),* 310-326.

Bieling, P.J., Perras, J., & Siotis, I. (2003, November). *Group cohesion in group CBT for depression: Does it matter?* Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, Boston, MA.

Birmaher, B., Ryan, N.D., Williamson, D.E., Brent, D.A., Kaufman, J., Dahl, R.E., et al. (1996). Childhood and adolescent depression: a review of the past 10 years. J*ournal of the American Academy of Child and Adolescent Psychiatry, 35(11),*

1427-1440.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, K.F., Clougherty, K.F., Wickramaratne, P., et al. (2003). Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *Journal of the American Medical Association, 289,* 3117–3124.

Bracero, W., (1998). Intimidades: Confianza, gender, and hierarch in the construction of Latino-Latina therapeutic relationships. *Cultural Diversity and Mental Health, 4*, 264-277.

Budman, S.H., Demby, A., Feldstein, M., Redondo, J., Scherz, B., Bennett, M. J., et al. (1987). Preliminary findings on a new instrument to measure cohesion in group psychotherapy. *International Journal of Group Psychotherapy, 37(1),* 75–94.

Budman, S.H., Soldz, S., Demby, A., Feldstein, M., Springer, T., & Davis, M. (1989). Cohesion, alliance and outcome in group psychotherapy. *Psychiatry, 52,* 339–350.

Burlingame, G.M., Fuhriman, A., & Johnson, J.E. (2001). Cohesion in group psychotherapy. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 71-88). New York: Oxford.

Butler, L.D., Miezitis, S., Friedman, R., & Cole, E. (1980). The effect of two school-based intervention programs on depressive symptoms in preadolescents. *American Educational Research Journal, 17(1)*, 111-119.

Butler, L. D., & Nolen-Hoeksema, S. (1994). Gender differences in responses to depressed mood in a college sample. *Sex Roles, 30,* 331–346.

Carey, M., Faulstich, M., Gresham, F., & Ruggiero, L. (1987). Children's Depression Inventory: Construct and discriminant validity across clinical and nonreferred (control) populations. *Journal of Consulting & Clinical Psychology, 55*, 755-761.

Cauce, A.M., & Rodriguez, M.D. (2001). Latino families: Myths and realities. In J.M. Contreras, A. Kerns, & A.M. Neal-Bernett (Eds.), *Latino children and families in the United States* (pp. 3 - 26). Westport, CT: Greenwood.

Chambers, W.J., Puig-Antich, J., Hirsch, M., Paez, P., Ambrosini, P.J., Tabrizi, M.A. et al. (1985). The assessment of affective disorders in children and adolescents by semistructured interview: Test-retest reliability for the schedule for affective disorders and schizophrenia for school-age children, present episode version. *Archives of General Psychiatry, 42*, 696-702.

Choi, H., Meininger, J.C., & Roberts, R.E. (2006). Ethnic differences in adolescents' mental distress, social stress, and resources. *Adolescence, 41*, 263–283

Clarke, P., Rhode, P., Lewinsohn, H., Hops, H., & Seeley, J.R. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 272–279.

Comas-Díaz, L. (1989). Puerto Rican women's cross-cultural transitions: Developmental and clinical implications. In C. García-Coll & L. Mattei (Eds.), *The psychosocial development of Puerto Rican women* (pp. 166-199). New York: Praeger.

Comas-Diaz L. (1996). Cultural considerations in diagnosis. In F.W. Kaslow (Ed.). *Handbook of relational diagnosis and dysfunctional family patterns.* (pp.152-

168). New York: John Wiley & Sons.

Corey, M.S., & Corey, G. (2006). Groups: Process and Practice. Belmont, CA: Thomson Wadsworth.

Costello, E.J., Angold, A., Burns, B.J., Stangl, D.K., Tweed, D.L., Erkanlie, A., et al. (1996). The Great Smoky Mountains study of youth: Goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry, 53*, 1129-1136.

Costello, E.J., Pine, D.S., Hammen, C., March, J.S., Plotsky, P.M., Weissman, M.M., et al. (2002). Development and natural history of mood disorders. *Biological Psychiatry, 52*, 529-542.

Coyne, J.C. (1976). Toward an interactional description of depression. *Psychiatry, 39,* 28-40.

Coyne, J. C. (1990). Interpersonal processes in depression. In I. Keitner (Ed.), *Depression and families: Impact and treatment* (pp. 31-53). Washington, DC: American Psychiatric Press.

Cuéllar, I. & Roberts, R.E. (1997). Relations of depression, acculturation, and socioeconomic status in a Latino sample. *Hispanic Journal of Behavioral Sciences, 19*, 230-238.

Culbertson, F.M. (1997). Depression and Gender. *American Psychologist, 52*, 25-31.

Curry, J. (2001). Specific psychotherapies for childhood and adolescent depression. *Biological Psychiatry, 49,* 1091–1100.

Curry, J.F. & Reinecke, M.A. (2003). Modular cognitive behavior therapy for adolescents

with major depression. In M. Reinecke, F. Durrilio, & A. Freeman (Eds.). *Cognitive therapy with children and adolescents* (2nd d., pp. 95-127). New York: Guilford Press.

David-Ferdon, C., & Kaslow, N.J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology, 37(1).* 62-104.

De Rios, M.D. (2001). *Brief psychotherapy with the Latino immigrant client.* New York: Haworth Press.

Doerfler, L.A., Felner, R.A., Rowlison, R.T., Raley, P.A., & Evans, E. (1988). Depression in children and adolescents: A comparative analysis of the utility and construct validity of two assessment measures. *Journal of Consulting and Clinical Psychology, 56*, 769-772.

Emslie, G., Kratochvil, C., Vitiello, B., Silva, S., Mayes, T., McNulty, S., et al. (2006). Treatment for Adolescents with Depression Study (TADS): safety results. *Journal of American Academy of Child and Adolescent Psychiatry, 45(12*), 1440-55.

Fergusson, D.M., Horwood, L.J., & Lynskey, M.T. (1993). Prevalence and comobidity of DSM-III-R diagnoses in a birth cohort of 15 year olds. *Journal of the American Academy of Child and Adolescent Psychiatry, 32(6*), 1127-1134.

Fleming J.E., & Offord D.R. (1990). Epidemiology of childhood depressive disorders: a critical review. *Journal of American Academy of Child and Adolescent Psychiatry, 29,* 571–580

Freeberg, A.L., & Stein, C.H. (1996). Felt obligations towards parents in Mexican-

American and Anglo-American young adults. *Journal of Social and Personal Relationships, 13,* 457–471.

Garrison, C.Z., Addy, C.L., Jackson, K.L., McKeown, R.E., & Waller, J.L. (1992). Major depressive disorder and dysthymia in young adolescents. *American Journal of Epidemiology, 135,* 792-802.

Gershon, E.S., Bunny, W.E., Leckman, J., Van Eerdwegh, M., & DeBauche, B. (1976). The inheritance of affective disorders: A review of data and hypotheses. *Behavior Genetics, 6,* 227-261.

Gilman, S.E., Kawachi, I., Fitzmaurice, G.M., & Buka, S.L. (2002). Socioeconoimc status in childhood and the lifetime risk of major depression. *International Journal of Epidemiology, 31*, 359-367.

Gloria, A.M., & Peregoy, J.J. (1996). Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment 13(2)*, 119-126.

Golding, J.M., & Lipton, R.I. (1990). Depressed mood and major depressive disorder in two ethnic groups. *Journal of Psychiatric Research, 24*, 65–82.

Goodyer, I.M., Herbert, J., Tamplin, A., Secher, S.M., & Pearson, J. (1997). Short-term outcome of major depression: I. Comorbidity and severity at presentation as predictors of persistent disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36(4)*, 474-480.

Gotlib, I.H., Lewinsohn, P.M., & Seeley, J.R. (1998). Consequences of depression during adolescence: Marital status and marital functioning in early adulthood. *Journal of*

Abnormal Psychology, 107(4), 686-690.

Gould, M.S., King, R., Greenwald, S., Fisher, P., Schwab-Stone, M., Kramer, R., et al. (1998). Psychopathology associated with suicidal ideation and attempts among children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry. 37(9*), 915-923.

Haley, G.M.T., Fine, S., Marriage, K., Moretti, M.M., & Freeman. R.J. (1985). Cognitive bias and depression in psychiatrically disturbed children and adolescents. *Journal of Consulting and Clinical Psychology, 53*(4), 535-537.

Hamet, P., & Tremblay, J. (2005). Genetics and genomics of depression. *Metabolism: Clinical and experimental, 54,* 10-15.

Hammen, C. & Rudolph, K.D. (2003). Childhood mood disorders. In E.J. Mash & R.A. Barkley (Eds.), *Child Psychopathology* (pp. 233-278). New York: Guilford Press.

Hammen, C. & Zupan, B.A. (1984). Self-schemas, depression, and the processing of personal information in children. *Journal of Experimental Child Psychology, 37*, 598-608.

Hand, I., Lamontagne, Y., & Marks, I. M. (1974). Group exposure (flooding) in vivo for agoraphobics. *British Journal of Psychiatry, 124*, 588–602.

Hankin, B. & Abramson, L. (2001). Development of gender differences in depression: An elaborated cognitive vulnerability-transactional stress theory. *Psychological Bulletin, 127(6),* 773-796.

Hankin, B.L., Abramson, L.Y., Miller, N., & Haeffel, G.J. (2004). Cognitive vulnerability–stress theories of depression: Examining affective specificity in the

prediction of depression versus anxiety in three prospective studies. *Cognitive Therapy and Research, 28*, 309–345.

Hays, P. A. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and Practice, 26,* 309-315.

Hofstede, G. (1980). *Culture's consequences.* Beverly Hills, CA: Sage.

Hornsey, M.J., Dwyer, L.I., & Oei, T.P.S. (2007). Beyond cohesiveness: Reconceptualizing the link between group processes and outcomes in group psychotherapy. *Small Group Research*, *38*, 567-592.

Horvath, A.O. (1994). Research on the alliance. In A.O. Horvath & L.S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 259–286). New York: Wiley.

Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223–233.

Hovey, J.D., & King, C.A. (1996) Acculturative stress, depression, and suicidal ideation among immigrants and second-generation Latino adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*, 1183-1192.

Hubble, M.A., Duncan, B.L., & Miller, S.D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Hui, C.H. (1988). Measurement of individualism–collectivism. *Journal of Research in Personality, 22,* 17–36.

Jacobs, K., Bhugra, D., & Mann, A. (2002). A randomized controlled trial of an educational intervention for depression among Asian women in primary care in

the United Kingdom. *International Journal of Social Psychiatry, 48,* 139–148.

Jaenicke, C., Hammen, C., Zupan, B., Hiroto, D., Gordon, D., Adrian, C., et al. (1987). Cognitive vulnerability in children at risk for depression. *Journal of Abnormal Child Psychology, 15(4),* 559-572.

Johnson, J.E., Burlingame, G.M., Olsen, J.A., Davies, D.R., & Gleave, R.L. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of Counseling Psychology, 52*, 310–321.

Joiner, T.E., & Metalsky, G.I. (1995). A prospective test of an integrative interpersonal theory of depression: A naturalistic study of college roommates. *Journal of Personality and Social Psychology, 69*, 778-788.

Joiner, T.E., Perez, M., Wagner, K D., Berenson, A., & Marquina, G.S. (2001). On fatalism, pessimism, and depressive symptoms among Mexican-American and other adolescents attending an obstetrics-gynecology clinic. *Behavior Research and Therapy, 39(8)*, 887-896.

Joyce, A.S., & Piper, W.E., & Ogrodniczuk, J.S. (2007). Therapeutic alliance and cohesion variables as predictors of outcome in short-term group psychotherapy. *International Journal of Group Psychotherapy, 57(3).* 269-296.

Kahn, J.S., Kehle, T.J., Jenson, W.R., & Clark, E. (1990). Comparison of cognitive-behavioral, relaxation, and self-modeling interventions for depression among middle-school students. *School Psychology Review, 19,* 196-211.

Kandel, D.B., & Davies, M. (1982). Epidemiology of depressive mood in adolescents. *Archives of General Psychiatry, 39*, 1205-1212.

Kandel, D.B. & Davies, M. (1986). Adult sequelae of adolescent depressive symptoms. *Archives of General Psychiatry, 43*, 255-262.

Kann, L., & Kinchen, S.A. (1998). Youth Risk Behavior Surveillance – United States, 1997. *MMWR: Morbidity & Mortality Weekly Report, 47* (Suppl. SS-3), 1-89.

Kaslow, N.J., Stark, K.D., Printz, B., Livingston, R., & Tsai, S. (1992). Cognitive Triad Inventory for Children: Development and Relation to Depression and Anxiety. *Journal of Clinical Child Psychology*, *21*, 339-347.

Kaslow, N.J., & Thompson, M.P. (1998). Applying the criteria for empirically-validated treatments (EVTs) to studies of psychosocial interventions for child and adolescent depression. *Journal of Clinical Child Psychology, 27*, 146-155.

Kazdin, A.E. (1990). Evaluation of the negative thoughts questionnaire: Negative cognitive processes and depression among children. *Psychological Assessment, 2*(1), 73-79.

Kazdin, A.E. & Weisz, J.R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66*, 19-36.

Keller, R. T. (1983). Predicting absenteeism from prior absenteeism, attitudinal factors, and nonattitudinal factors. *Journal of Applied Psychology, 68,* 536-540.

Kendall, P.C., Stark, K.D., & Adams, T. (1990). Cognitive deficit or cognitive distortion of childhood depression. *Journal of Abnormal Child Psychology, 18*(3), 255-270.

Kessler, R.C., McGongale, K.A. Zhao, S., Nelson, C.B., Hughes, M., Eshelman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8–19.

Klerman, G.K. & Weissman, M.M. (1989). Increasing rates of depression. *Journal of the American Medical Association*, *261*, 2229-2235.

Kovacs, M. (1981). Rating scales to assess depression in school-aged children. *International Journal of Child & Adolescent Psychiatry, 46(5-sup-6)*, 305-315.

Kovacs, M. (1992). *Children's depression inventory (CDI) manual*. North Tonawanda, NY: Multi-Health Systems, Inc.

Kovacs, M. & Beck, A.T. (1978). Maladaptive cognitive structures in depression. *American Journal of Psychiatry, 135*, 525-533.

Kovacs, M., Feinberg, T.L., Crouse-Novak, M.A., Paulauskas, S.L., & Finkelstein, R. (1984). Depressive disorders in childhood, I. A longitudinal prospective study of characteristics and recovery. *Archives of General Psychiatry*, *41,* 229-237.

Lakdawalla, L., Hankin, B.L., & Mermelstein, R. (2007). Cognitive Theories of Depression in Children and Adolescents: A Conceptual and Quantitative Review. *Clinical Child and Family Psychology Review, 10(1),* 1-24.

Last, C.G. & Strauss, C.C. (1990). School refusal in anxiety disordered children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 31-35.

Lewinsohn, P.M. (1974). A behavioral approach to depression. In R.J. Friedman & M.M. Katz (Eds.), *The psychology of depression: Contemporary theory and research*.

New York: John Wiley & Sons.

Lewinsohn, P.M. & Clark, G.M. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, 19*(3), 329-342.

Lewinsohn, P.M., Clarke, G.N., Hops, H., & Andrews, J.A. (1990). Cognitive-behavioral treatment for depressed adolescents. *Behavior Therapy, 21(4),* 385-401.

Lewinsohn, P.M., Clarke, G., Rohde, P., Hops, H., & Seeley, J. (1996). A course in coping: A cognitive–behavioral approach to the treatment of adolescent depression. In E.D. Hibbs & P.S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 109–135). Washington, DC: American Psychological Association.

Lewinsohn, P.M., Clarke, G.N., Seeley, J.R., & Rohde, P. (1994a). Major depression in community adolescents: Age at onset, episode duration, and time to recurrence. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 809-818.

Lewinsohn, P.M., Hops, H., Roberts, R.E., Seeley, J.R., & Andrews, J.A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in high school students. Journal of Abnormal Psychology, 102, 133-144.

Lewinsohn, P.M., Roberts, R.E., Seeley, J.R., Rhode, P., Gotlib, I.H., Hops, H. (1994b). Adolescent psychopathology II: Psychosocial risk factors for depression. *Journal of Abnormal Psychology, 103(2),* 302-315.

Lewinsohn, P. M., Rohde, P., Klein, D. M., & Seeley, J. R (1999). Natural course of adolescent major depressive disorder I: Continuity into young adulthood. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 56-63.

Lewis-Fernandez, R., & Kleinman, A. (1994). Culture, personality, and psychopathology. *Journal of Abnormal Psychology, 103,* 67-71.

Lorentzen, S., Sexton, P.H., & Høglend, P. (2004). Therapeutic alliance, cohesion and outcome in a long-term analytic group: A preliminary study. *Nordic Journal of Psychiatry, 58*, 33–40.

Luborsky, L., Barber, J., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., et al. (1996) The Revised Helping Alliance Questionnaire (HAq-II): Psychometric properties. *Journal of Psychotherapy Practice and Research, 5*, 260-271.

MacKenzie, K. R. (1998). The alliance in time-limited group psychotherapy. In J.D. Safran & J.C. Muran (Eds.), *The therapeutic alliance in brief psychotherapy* (pp. 193–215). Washington, DC: American Psychological Association.

March, J., Silva, S., Petrycki. S., Curry, J., Wells, K., Fairbank, J., et al. (2004) Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292(7),* 807-20.

March, J., Silva, S., & Vitiello, B. (2006). The Treatment for Adolescents with Depression Study (TADS): Methods and message at 12 weeks. *Journal of the American Academy of Child and Adolescent Psychiatry, 45(12)*, 393-403.

Markus, H.R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*, 224-253.

Marsella, A., & Yamada, A.M. (2000). Culture and mental health: An introduction and overview of foundations, concepts and issues. In I. Cuéllar & F. Paniagua (Eds.), *Handbook of multicultural mental health* (pp. 3-22). San Diego: Academic.

Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta–analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438–450.

Marziali, E., Munroe-Blum, H., & McCleary, L. (1997). The contribution of group cohesion and group alliance to the outcome of group psychotherapy. *International Journal of Group Psychotherapy, 47,* 475–497.

Metalsky, G.I., & Joiner, T.E. (1997). The hopelessness depression symptom questionnaire. *Cognitive Therapy and Research, 21*, 359–384.

Miranda, J., Chung, J.Y., Green, B.L., Krupnick, J., Siddique, J., Revicki, D.A., et al. (2003). Treating depression in predominantly low-income young minority women: A randomized controlled trial. *Journal of the American Medical Association, 290*, 57–65.

Mirowsky, J., & Ross, C.E. (1984). Mexican culture and its emotional contradictions. *Journal of Health and Social Behavior, 25*, 2-13.

Moos, R.H. (1986). *Group environment Scale manual* (2"" ed.). Palo Alto, CA: Consulting Psychologists Press.

Neff, J.A., & Hoppe, S.K. (1993). Race/ethnicity, acculturation, and psychological distress: fatalism and religiosity as cultural resources. *Journal of Community Psychology, 21*, 3-20.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology*, *100(4),* 569-582.

Nolen-Hoeksema, S. (1995). Epidemiology and theories of gender differences in unipolar depression. In M.V. Seeman (Ed.) *Gender and Psychopathology* (pp.63-87). Washington, DC: American Psychiatric Press.

Nolen-Hoeksema, S., & Morrow, J. (1991). A prospective study of depression and posttraumatic stress symptoms after a natural disaster: The 1989 Loma Prieta earthquake. *Journal of Personality and Social Psychology, 61*, 115–121.

Oei, T.P.S., & Browne, A. (2006). Components of group processes: Have they contributed to the outcome of mood and anxiety disorder patients in a group cognitive-behaviour therapy program? *American Journal of Psychotherapy, 60*, 53-70.

Office of Management and Budget. (1997). *Federal Register Notice*. Washington, DC: U.S. Government Printing Office.

Organista, K.C. (2003). Mexican American children and adolescents. In J.T. Gibbs & L.N. Huang (Eds.), *Children of color: Psychological interventions with culturally diverse youth* (pp. 344-381). San Francisco, CA: Jossey-Bass.

Organista, K.C., Mufioz, R.F, & Gonzalez, G. (1994). Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: Description of a

program and exploratory analyses. *Cognitive Therapy and Research, 18,* 241-259.

Oyserman, D., Coon, H.M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128(1),* 3-72

Paniagua, F.A. (1994). Assessing and treating culturally diverse clients. Thousand Oaks, CA: Sage.

Prieto, S.L, Cole, D.A., & Tageson, C.W. (1992). Depressive self-schemas in clinic and nonclinic children. *Cognitive Therapy and Research, 16(5).* 521-534.

Proctor, B., & Dalaker, J. (2002). *Current population reports. Poverty in the United States: 2001*. Washington, DC: U.S. Census Bureau.

Puig-Antich, J., Kaufman, J., Ryan, N.D., Williamson, D.E., Dahl, R.E., Lukens, E., et al. (1993). The psychosocial functioning and family environment of depressed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32(2), 244-253.

Puig-Anitch, J., Lukens, E., Davies, M., Goetz, D., Brennan-Quattrock, J., & Todak, G. (1985). Psychosocial functioning in prepubertal major depressive disorders I: Interpersonal relationships during the depressive episode. *Archives of General Psychiatry*, *42*, 500-507.

Ramírez, O. (1990). Mexican American children and adolescents. In J.T. Gibbs & L. N. Huang (Eds.), *Children of color* (pp. 224-250). San Francisco: Jossey-Bass.

Ramirez, R.R., & De la Cruz, G.P. (2002). The Hispanic population in the United States: March 2002. *Current Population Reports,* p. 20–545. Washington, DC: U.S. Census Bureau.

Rao, U., Ryan, N.D., Birmaher, B., Williamson, D.E., & Kaufman, J. (1995). Unipolar depression in adolescents: Clinical outcome in adulthood. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(5), 566-578.

Reinecke, M.A., Ryan, N.E., & Dubois, D.L. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 37(1*), 26-34

Reynolds, C.R. (1986). The elusive professionalism of school psychology: Lessons from the past, portents for the future. *Professional School Psychology, 1(1),* 41-46.

Roberts, R.E. (1994). An exploration of depression among Mexican origin and Anglo adolescents. In R. Malgady & O. Rodriguez (Eds.), *Theoretical and Conceptual Issues in Hispanic Mental Health Research* (pp.92-112). Malabar, FL: Krieger Publishing Company.

Roberts, R.E., & Chen, Y.C. (1995). Depressive symptoms and suicidal ideation among Mexican Origin and Anglo adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 34*, 81-90.

Roberts, R.E., Roberts, C.R., & Chen Y.R. (1997). Ethnocultural differences in prevalence of adolescent depression. *American Journal of Community Psychology, 25(1)*, 95-110.

Roberts, R.E., & Sobhan, M. (1992). Symptoms of depression in adolescence: A comparison of Anglo, African, and Hispanic Americas. *Journal of Youth Adolescence, 21*, 639-651.

Rochín, R.I. & de la Torre, A. (1996). Chicanas/os in the economy since 1970. In D.R. Maciel & I.D. Ortiz (Eds.), *Chicanas/Chicanos at the Crossroads* (pp. 52-80). Tucson: The University of Arizona Press.

Rohde, P., Lewinsohn, P.M., Seeley, J.R. (1991). Comorbidity of unipolar depression II: Comorbidity with other mental disorders in adolescents and adults. Journal of Abnormal Psychology, 100(2), 214-222.

Rohde, P., Seeley, J.R., Kaufman, N.K., Clarke, G.N., & Stice, E. (2006). Predicting time to recovery among depressed adolescents treated in two group interventions. *Journal of Consulting and Clinical Psychology, 74,* 80-88.

Rosello, J., & Bernal, G. (1999). The efficacy of cognitive– behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology, 67,* 734–745.

Rossello, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and Group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology, 14(3),* 234-245.

Ross, C.E., Mirowsky, J., & Cockerham, W.C. (1983) Social class, Mexican culture, and fatalism: Their effects on psychological distress. *American Journal of Community Psychology, 11,* 383-399.

Rush, A.J. & Beck, A.T. (1978). Cognitive therapy of depression and suicide. *American Journal of Psychotherapy*, *32*, 201-219.

Santiago-Rivera, A.L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling and la familia: A practical guide*. Thousand Oaks: Sage Publications.

Schiff, M., Suvak, M.K., Antony, M.M., Bieling, P.J., & McCabe, R.E. (2007). Group cohesion in cognitive-behavioral group therapy for social phobia. *Behaviour Research and Therapy, 45*, 687–698.

Schwartz, J.A.J., & Koenig, L.J. (1996). Response styles & negative affect among adolescents. *Cognitive Therapy & Research, 20,* 13–36.

Scott, J., & Watkins, E. (2004). Brief psychotherapies for depression: Current status. *Current Opinion in Psychiatry, 17*, 3-7.

Seligman, M.E. (1975). *Helplessness: on depression, development, and death*. San Francisco: W.H. Freeman.

Shaffer, D., Gould, M.S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., et al. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53(4)*. 339-348.

Shkodrianai, G.M., & Gibbons, J.L. (1995). Individualism and collectivism among university students in Mexican and the United States. *The Journal of Social Psychology, 135*, 765-772.

Siegel, J.M., Aneshensel, C.S., Taub, B., Cantwell, D.P., & Driscoll, A.K. (1998). Adolescent depressed mood in a multiethnic sample. *Journal of Youth and Adolescence, 27(4),* 413-427.

Smucker, M.R., Craighead, W.E., Craighead, L.W., & Green, B. (1986). Normative and reliability data for the Children's Depression Inventory. *Journal of Abnormal Child Psychology, 14(1),* 25-39.

Soares, J.C., & Mann, J.J. (1997). The anatomy of mood disorders: Review of structural neuroimaging studies. *Biological Psychiatry, 42,* 86-106.

Stark, K.D. (1990). *The treatment of depression during childhood: A school-based program*. New York: Guilford Press.

Stark, K.D., Humphrey, L.L., Laurent, L., Livingston, R., & Christopher, J. (1993). Cognitive, behavioral, and family factors in the differentiation of depressive and anxiety disorders during childhood. *Journal of Consulting and Clinical Psychology, 61*(5), 878-886.

Stark, K.D., Reynolds, W.M., & Kaslow, N.J. (1987). A comparison of the relative efficacy of self-control therapy and a behavioral problem-solving therapy for depression in children. *Journal of Abnormal Child Psychology, 15(1),* 91-113.

Stark, K.D., Rouse, L., & Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive behavioral procedures for the individual and family. In P. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (pp. 165–206). New York: Guilford Press.

Stark, K.D. & Sander, J.B. (2002). *Diagnostic and statistical manual brief symptom interview for depression*. Unpublished Manuscript, University of Texas at Austin.

Stark, K.D., Sander, J.B., Yancy, M.G., Bronik, M.D., & Hoke, J.A. (2000). Treatment of depression in childhood and adolescence: Cognitive-behavioral procedures for the

individual and the family. In P.C. Kendall, *Child and adolescent therapy: Cognitive-behavioral procedures* (2nd ed, pp. 173-234,). New York: Guilford Press.

Taft, C.T., Murphy, C.M., King, D.W., Musser, P.H., & DeDeyn, J.M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 71,* 812–820.

Teasdale, J.D., Walsh, P.A., Lancashire, M., & Matthews, A.M. (1977). Group exposure of agoraphobics: A replication study. *British Journal of Psychiatry, 130,* 186–193.

Timbremont, B., Braet, C., & Dreesen, L. (2004). Assessing Depression in Youth: Relation Between the Children's Depression Inventory and a Structured Interview. *Journal of Clinical Child & Adolescent Psychology, 33*, 149-157.

Tortolero, S.R., & Roberts, R.E. (2001). Differences in nonfatal suicide behaviors among Mexican and European American middle school children. *Suicide and Life-Threatening Behavior 31(2)*, 214-223.

Treadwell, T., Laverture, N., Kumar, V. K., & Veeraraghavan, V. (2001). The group cohesion scale-revised: reliability and validity. *International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing, 54*, 3–12.

Triandis, H.C., Bontempo, R., Villareal, M.J., Asai, M., & Lucca, N. (1988). Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. *Journal of Personality and Social Psychology, 54,* 323–338.

Triandis, H.C., Marín, G., Lisansky, J., & Betancourt, H. (1984). Simpatía as a cultural script of Hispanics. *Journal of Personality and Social Psychology, 47*, 1363-1375.

Triandis, H.C., McCusker, C., & Hui, C.H. (1990). Multimethod probes of individualism and collectivism. *Journal of Personality and Social Psychology, 59,* 1006–1020.

Tschuschke, V., & Dies, R.R. (1994). Intensive analysis of therapeutic factors and outcome in long-term inpatient groups. *International Journal of Group Psychotherapy, 44*, 185–208.

United States Census Bureau. (2006). *Population Profile of the United States.* Washington, DC: U.S. Government Printing Office.

Varela, R. E., Vernberg, E. M., Sanchez-Sosa, J. J., Riveros, A., Mitchell, M., Mashunkashey, J. (2004). Anxiety reporting and culturally associate interpretation biases and cognitive schemas: A comparison of Mexican, Mexican American, and European American Families. *Journal of Clinical Child and Adolescent Psychology, 33(2)*, 237-247.

Vega, W.A., Gil, A.G., Zimmerman, R.S., & Warheit, G.J. (1993). Risk factors for suicidal behavior among Hispanic, African-American, non-Hispanic white boys in early adolescents. *Ethnicity and Disease*, *3*, 229–241.

Weersing, V.R., & Weisz, J.R. (2002). Mechanisms of action in youth psychotherapy. *Journal of Child Psychology and Psychiatry, 43*, 3–29.

Weinberg, W.A., & Emslie, G.J. (1987). Depression and suicide in adolescents. *International Pediatrics, 2*, 154-159.

Weisz, J.R., Doss, A.J., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology, 56*, 337–363.

Weisz, J.R., McCarty, C.A., & Valeri, S.M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin, 132(1).* 132-149.

Weisz, J.R., Thurber, C.A., Sweeney, L., Proffitt, V.D., & LeGagnoux, G.L. (1997). Brief treatment of mild to moderate child depression using primary and secondary control enhancement training. *Journal of Consulting and Clinical Psychology, 65*, 703-707.

Woody, S.R., & Adessky, R.S. (2002). Therapeutic alliance, group cohesion, and homework compliance during cognitive-behavioral group treatment of social phobia. *Behavior Therapy, 33,* 5–27.

Yalom, I.D. (1995). *The theory and practice of group psychotherapy* (4 ed.). New York: Basic Books.

Zupan, B.A., Hammen, C., & Jaenicke, C. (1987). The effects of current mood and prior depressive history on self-schematic processing in children. *Journal of Experimental Child Psychology, 43*, 149-158.

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